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 1-218-728-4231 or 1-800-570-1012. 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.dol.gov/ebsa/healthreform or call 1-218-728-4231 or 1-800-570-1012 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$200 person/$400 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. Online and Telehealth visits, and preventive services from other in-network providers and out-of-network providers up to $250 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.
Are there other deductibles for specific services?	Yes. $50 emergency room care deductible per visit. 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?	$1,200 person/$2,400 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, emergency room care deductible, 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 www.bluecrossmn.com 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
		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	15% coinsurance	15% coinsurance	None
	Specialist visit	15% coinsurance	15% coinsurance	None
	Preventive care/screening/ immunization	Other In-Network Providers: No charge up to $250 and deductible does not apply, then 15% coinsurance for charges over $250	No charge up to $250 and deductible does not apply, then 15% coinsurance for charges over $250	None
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	15% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	15% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at 1-218-728-4231 or 1-800-570-1012 and at myprime.com.	Generic and brand name drugs	15% coinsurance (retail & mail order)	Not covered	Covers a 90-day supply. Use mail order program for long-term or maintenance drugs.
	Specialty drugs	15% coinsurance	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)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	15% coinsurance	None
	Physician/surgeon fees	15% coinsurance	15% coinsurance	None
If you need immediate medical attention	Emergency room care	15% coinsurance after $50 deductible/visit	15% coinsurance after $50 deductible/visit	Deductible waived if admitted to hospital within 24 hours of emergency room visit or if plan pays secondary.
	Emergency medical transportation	15% coinsurance	15% coinsurance	Coverage is limited to one trip per injury or sickness.
	Urgent care	15% coinsurance	15% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	Not covered	None
	Physician/surgeon fees	15% coinsurance	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance	15% coinsurance	None
	Inpatient services	15% coinsurance.	Not covered	None
If you are pregnant	Office visits	15% coinsurance	15% coinsurance	None
	Childbirth/delivery professional services	15% coinsurance	Not covered	None
	Childbirth/delivery facility services	15% coinsurance	Not covered	None

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 help recovering or have other special health needs	Home health care	15% coinsurance	15% coinsurance	Must be approved in writing and established by the attending Physician; 30 months lifetime maximum.
	Rehabilitation services	15% coinsurance	15% coinsurance for outpatient services; inpatient services are not covered	Limited to 24 visits per person per calendar year. Additional therapy visits available following a medical review if the treatment is expected to make significant measurable improvement to the condition within a reasonable and predictable period of time.
	Habilitation services	15% coinsurance	15% coinsurance; for outpatient services; inpatient services are not covered	
	Skilled nursing care	15% coinsurance	15% coinsurance for outpatient services; inpatient services are not covered	Coverage is limited to 20 days per period of disability unless additional days are certified by a medical doctor.
	Durable medical equipment	15% coinsurance	15% coinsurance	Rental of equipment not to exceed purchase price.
	Hospice services	15% coinsurance	15% coinsurance for outpatient services; inpatient services are not covered.	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	Coverage includes 1 pair of lenses for glasses and/or 1 order of contacts every calendar year. Frames and other hardware are subject to a $250 limit every two years.
	Children's glasses	No charge	No charge	
	Children's dental check-up	No charge	No charge	

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.)

- Bariatric surgery
- Cosmetic surgery (except for injury, birth defects, and reconstructive surgery following mastectomy)
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture (up to 15 visits per calendar year)
- Chiropractic care (up to 15 visits per calendar year)
- Dental care (Adult) (up to $1,000 per person per calendar year; limit does not apply to individuals under age 19)
- Hearing aids (up to $1,000 once every five years)
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult) (up to $250 per person every two calendar years; limit does not apply to individuals under age 19)

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: the Plan at 1-218-728-4231 or 1-800-570-1012. 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.

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.

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	$200
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$200
Copayments	$0
Coinsurance	$1,000
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	$1,220

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

The plan's overall deductible	$200
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$200
Copayments	$0
Coinsurance	$780
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,000

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

The plan's overall deductible	$200
Specialist coinsurance	15%
Hospital (facility) coinsurance	15%
Other coinsurance	15%

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	$0
Coinsurance	$380
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$630

*Note: In addition to the overall deductible, this coverage example includes a $50 deductible for the emergency room care visit. The plan would be responsible for the other costs of these EXAMPLE covered services.