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.dol.gov/ebsa/healthreform or call 952-854-0795 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$200** person/**$600** 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Prescription drugs, first $500 of preventive care, Doctor on Demand, hearing aid, vision, orthotic benefits, and type A dental 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.
Are there other deductibles for specific services?	Yes. **$70** for dental care (except type A dental services) every two calendar years. 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: **$1,500** person/**$4,500** family Prescription drugs: **$3,000** person	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, deductibles, prescription drugs, chiropractic, dental, hearing aid, vision, orthotic benefits, 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.bcbsmn.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
		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 available at no charge; deductible does not apply.
	Specialist visit			
	Preventive care/screening/ immunization	No charge up to $500; deductible does not apply. Charges in excess of $500 subject to 20% coinsurance.	No charge up to $500; deductible does not apply. Charges in excess of $500 subject to 20% 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)	20% coinsurance	20% coinsurance	Medically necessary genetic testing covered up to $2,500 per person per year and $10,000 lifetime maximum.
	Imaging (CT/PET scans, MRIs)			None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at (800) 228-3108 or savrx.com.	Generic drugs	20% coinsurance. Deductible does not apply.	20% coinsurance. Deductible does not apply.	Covers up to a 34-day supply (retail); 90 day supply mail order. $5 minimum. Prescription drugs and over-the-counter tobacco cessation products are covered with a doctor's prescription. Subject to $3,000 prescription drug out-of-pocket limit.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs		Not covered	Must use Sav-Rx Specialty Pharmacy Suppliers only; 90-day supply. Subject to $3,000 prescription drug out-of-pocket limit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees			

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 immediate medical attention	Emergency room care	$100 copayment/visit; subject to 20% coinsurance.	$100 copayment/visit; subject to 20% coinsurance.	Copay waived if admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Covers emergency medical transportation to first hospital where treatment is given and to a subsequent hospital if such transfer is medically necessary.
	Urgent care			None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance for outpatient services; inpatient services are not covered	Up to the average semiprivate room charge. Out-of-network inpatient services are covered only if it is an emergency medical condition.
	Physician/surgeon fees			
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance	Doctor on Demand available at no charge; deductible does not apply
	Inpatient services		Not covered	Out-of-network inpatient services are covered only if it is an emergency medical condition.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance	Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound). Out-of-network inpatient maternity services are covered only if it is an emergency medical condition.
	Childbirth/delivery professional services		Not covered	
	Childbirth/delivery facility services		Not covered	

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 help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	Coverage is limited to 120 visits per calendar year.
	Rehabilitation services		20% coinsurance for outpatient services; inpatient services are not covered	Services or supplies provided by a skilled nursing facility or chiropractor are not covered. Out-of-network inpatient services are covered only if it is an emergency medical condition.
	Habilitation services			Out-of-network inpatient services are covered only if it is an emergency medical condition.
	Skilled nursing care	No charge	No charge for outpatient services; inpatient services are not covered	Maximum of 60 days per period of confinement covered. Out-of-network inpatient services are covered only if it is an emergency medical condition.
	Durable medical equipment	20% coinsurance	20% coinsurance	Only rental of equipment covered.
	Hospice services		20% coinsurance for outpatient services; inpatient services are not covered	Coverage is limited to 185 days per lifetime. Out-of-network inpatient services are covered only if it is an emergency medical condition.
If your child needs dental or eye care	Children's eye exam	No charge. Deductible does not apply.	No charge. Deductible does not apply.	None
	Children's glasses			
	Children's dental check-up	No charge. Medical and dental deductibles do not apply.	No charge. Medical and dental deductibles do not apply.	Limited to 2 oral examinations per calendar year. Oral examinations include the scaling and cleaning of teeth.

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 (except to rebuild or correct a body part after injury, sickness, or disease; to rebuild or correct a functional defect present at birth; or reconstructive surgery following mastectomy)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (up to 26 visits per calendar year, in combination with the chiropractic benefit limit) • Bariatric surgery (must be medically necessary because of an organic dysfunction) • Chiropractic care (up to 26 visits per calendar year, in combination with the acupuncture limit)	• Dental care (Adult) (limited to $3,000 every two calendar years; limit does not apply to individuals under age 19) • Hearing aids (limited to $4,000 once every five calendar years) • Infertility treatment (limited to $7,500 per lifetime)	• Private-duty nursing (must not reside in patient's home or be a member of the patient's or patient's spouse's family) • Routine eye care (Adult) (limited to $700 per person every two calendar years; limit does not apply to individuals under age 19) • Weight loss programs (must be medically necessary because of an organic dysfunction)

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: you can 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.

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 network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$200**
■ **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	$200
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,760**

Managing Joe's Type 2 Diabetes

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

■ **The plan's overall deductible**	**$200**
■ **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	$200
Copayments	$0
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$290
The total Joe would pay is	**$1,590**

Mia's Simple Fracture

(network emergency room visit and follow up care)

■ **The plan's overall deductible**	**$200**
■ **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	$200
Copayments	$100
Coinsurance	$500
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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