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, visit [https://www.bluecrossmn.com/umnga](https://www.bluecrossmn.com/umnga) or call 1-866-866-0348. 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 [https://www.healthcare.gov/sbc-glossary](https://www.healthcare.gov/sbc-glossary) or call 1-866-866-0348 to request a copy.

**Important Questions** | **Answers** | **Why This Matters:**
--- | --- | ---
What is the overall deductible? | $200 individual medical out-of-network <br>$600 family medical out-of-network | 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. In-network office visit copayments, Out-of-network well-child care, prenatal care, emergency room care, emergency medical transportation, and durable medical equipment 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](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. 

What is the out-of-pocket limit for this plan? | $2,500 individual medical combined in-network and out-of-network; $5,000 family medical combined in-network and out-of-network
Pharmacy: $300 individual / $600 family | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on 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-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.bluecrossmn.com/umngap or call 1-866-866-0348 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 in-network **provider** might use an **out-of-network provider** for some services (such as laboratory 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**. |

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

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>If you visit a health care <strong>provider’s</strong> office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$10 office visit <strong>copayment</strong> per visit; $5 convenience clinic <strong>copayment</strong> per visit; no charge for all other services <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Specialist</strong> visit</td>
<td>$10 office visit <strong>copayment</strong> per visit; no charge for all other services <strong>deductible</strong> does not apply</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Preventive care/screening/immunization</strong></td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td><strong>Diagnostic test</strong> (x-ray, blood work)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition. More information about <strong>prescription drug coverage</strong> is available at <a href="http://www.myprime.com">www.myprime.com</a>.</td>
<td>Preferred generic drugs</td>
<td>$10.00 <strong>copayment</strong>/retail <strong>Deductible</strong> does not apply</td>
<td>$10.00 <strong>copayment</strong>/retail <strong>Deductible</strong> does not apply</td>
</tr>
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<td>-------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------</td>
</tr>
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<td></td>
<td></td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$25.00 copayment/retail $50.00 copayment/mail service $50.00 copayment/90dayRx retail Deductible does not apply</td>
<td>$25.00 copayment/retail Deductible does not apply</td>
</tr>
<tr>
<td>Preferred brand drugs</td>
<td></td>
<td></td>
<td>No coverage for mail service and 90dayRx retail drugs from out-of-network providers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred generic</td>
<td></td>
<td>$50.00 copayment/retail $100.00 copayment/mail service $100.00 copayment/90dayRx retail Deductible does not apply</td>
<td>$50.00 copayment/retail Deductible does not apply</td>
</tr>
<tr>
<td>drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-preferred brand name</td>
<td></td>
<td>$50.00 copayment/retail $100.00 copayment/mail service $100.00 copayment/90dayRx retail Deductible does not apply</td>
<td>$50.00 copayment/retail Deductible does not apply</td>
</tr>
<tr>
<td>drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialty drugs</td>
<td>Preferred Generic: $10.00 copayment/prescription, Preferred Brand: $25.00 copayment/prescription; Non-preferred: $50.00 copayment/prescription Deductible does not apply 100% coverage after copayment for all</td>
<td>Not covered</td>
<td>Covers up to a 34-day supply (participating specialty drug network supplier prescription). No coverage for services out-of-network providers.</td>
</tr>
<tr>
<td>If you have outpatient</td>
<td>Facility fee (e.g., ambulatory surgery</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>surgery</td>
<td>center)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td><strong>In-Network Provider</strong> &lt;br&gt;$40.00 copayment/visit deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td><strong>Out-of-Network Provider</strong> &lt;br&gt;$40 copayment/visit; deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$10 office visit copayment per visit; no charge for all other services deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$10 office visit copayment per visit; deductible does not apply; no charge for all other services</td>
<td>Services for marriage/couples counseling are not covered.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>Limit of 120 visits per benefit period when you use in-network providers. Limit of 60 visits per benefit period when you use out-of-network providers.</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td><strong>Rehabilitation services</strong></td>
<td>$10 office visit <strong>copayment</strong> per visit for occupational therapy; no charge for therapies</td>
<td>20% <strong>coinsurance</strong> for occupational therapy 20% <strong>coinsurance</strong> for physical therapy 20% <strong>coinsurance</strong> for speech therapy</td>
</tr>
<tr>
<td></td>
<td><strong>Habilitation services</strong></td>
<td>$10 office visit <strong>copayment</strong> per visit for occupational therapy; no charge for therapies</td>
<td>20% <strong>coinsurance</strong> for occupational therapy 20% <strong>coinsurance</strong> for physical therapy 20% <strong>coinsurance</strong> for speech therapy</td>
</tr>
<tr>
<td></td>
<td><strong>Skilled nursing care</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td><strong>Durable medical equipment</strong></td>
<td>20% <strong>coinsurance</strong>; deductible does not apply</td>
<td>20% <strong>coinsurance</strong>; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td><strong>Hospice services</strong></td>
<td>No charge</td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td><strong>Children's eye exam</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children's glasses</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Children's dental check-up</strong></td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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 (unless for removal of port wine stain, reconstructive surgery)
- Long-term care
- Routine foot care
- Dental care (Adult)
- Private duty nursing
- Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)

- Acupuncture for treatment of chronic pain (defined as a duration of at least six months) or for the prevention and treatment of nausea associated with surgery, chemotherapy, or pregnancy
- Bariatric surgery
- Chiropractic care
- Hearing aids (limited to one external hearing aid for each ear every three years)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.ccio.cms.gov. Other coverage options are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596. For more information on Student Services Fee benefits at Boynton Health visit https://boynont.umn.edu/insurance-billing-fees/student-services-fee.

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: Blue Cross at 1-866-873-5943 or if you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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? Not Applicable. 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:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.
Haddi aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

لا فهم اللغة العربية، تتوفر لك خدمات المساعدة اللغة المجانية. اتصل بالرقم 866-569-1213 لل هاتف النصي اتصل بالرقم 711.

إذا كنت تتحدث العربي، تتوفر لك خدمات المساعدة اللغة المجانية. اتصل بالرقم 866-569-1213 لل هاتف النصي اتصل بالرقم 711.

Afaan Oromoo dubbattu yoo ta’e, tajaaajila gargaarsa afaan hikku kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bibilaa.

如果您想說中文，我們可以為您提供免費的語言援助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。
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, copayment 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 prenatal care and a hospital delivery)

- **The plan’s overall deductible**: $0
- **Specialist copayment**: $10
- **Hospital (facility) coinsurance**: 0%
- **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: $0
  - Copayments: $60
  - Coinsurance: $0

  **What isn’t covered**
  - Limits or exclusions: $60
  - The total Peg would pay is: $120

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

- **The plan’s overall deductible**: $0
- **Specialist coinsurance**: $10
- **Hospital (facility) coinsurance**: 0%
- **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: $0
  - Copayments: $700
  - Coinsurance: $400

  **What isn’t covered**
  - Limits or exclusions: $60
  - The total Joe would pay is: $1,160

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

- **The plan’s overall deductible**: $0
- **Specialist coinsurance**: $10
- **Hospital (facility) coinsurance**: 0%
- **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: $0
  - Copayments: $200
  - Coinsurance: $200

  **What isn’t covered**
  - Limits or exclusions: $0
  - The total Mia would pay is: $400

The plan would be responsible for the other costs of these EXAMPLE covered services.
Notice of Nondiscrimination Practices
Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:
- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator
- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by telephone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights
- electronically through the Office for Civil Rights Complaint Portal, available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by telephone at: 1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201