Office of Administration



P.O. Box 610 | Crookston, Minnesota | 56716 T: (218) 281-4533 | F: (218) 281-5991

Summary of Benefits and Coverage Delivery Receipt

Individual	Information

Issuer Name:	Diocese of Crookston	
Member Name:		
Home Address:	·	
City, State:	:	Zip:
Social Security #		
Phone #		

Instructions

Based on the requirements of the Patient Protection and Affordable Care Act ("PPACA"), we are required to provide participants and beneficiaries with a Summary of Benefits and Coverage ("SBC"). Entities that fail to provide information to a participant or beneficiary are subject to a \$1,000.00 fine for each offense. A failure, with respect to each participant or beneficiary, constitutes a separate offense.

Due to the severity and retroactive nature of these penalties, we are asking that all of our members acknowledge receipt of their SBC.

Acknowledgement

I, ______acknowledge receipt of the Summary of Benefits and Coverage for my policy. Further, I am aware that an SBC, may be provided in paper form or electronically. My receipt of the SBC is not conditioned on my accepting benefits.

I further acknowledge that this document cannot be altered by addition or deletion of information after it has been signed.

Member name:	Date:
lssuer representative:	Date:



Blue Cross" and Blue Shleid" of Minnesota and Blue Plus[®] are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services DIOCESE OF CROOKSTON

Coverage Period: Beginning on or after 04/01/2021

Coverage for: Individual/Family | Plan Type: PPO



1-866-873-5943. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossmnonline.com or call toll-free the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$500 individual medical combined <u>in-</u> <u>network</u> and <u>out-of-network</u> \$1,500 family medical combined <u>in-</u> <u>network</u> and <u>out-of-network</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care, prenatal care and in-network preventive care services are covered before you meet your deductible.	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-carebenefits/</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$1,500 individual medical combined <u>in-</u> <u>network</u> and <u>out-of-network</u> \$4,500 family medical combined <u>in-</u> <u>network</u> and <u>out-of-network</u> \$750 individual drug combined <u>in-</u> <u>network</u> and <u>out-of-network</u> \$1,000 family drug combined <u>in-network</u> and <u>out-of-network</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-</u> 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.

Do you need a <u>referral</u> to see a <u>specialist</u> ?	Will you pay less if you use an in-network provider?
No.	Yes. See <u>https://www.bluecrossmnonline.com/find-a-doctor/#/home</u> or call toll-free 1-866- 873-5943 for a list of <u>in-network</u> <u>providers</u> .
You can see the <u>specialist</u> you choose without a <u>referral</u> .	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.



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

		What you Will	ı Will Pay	Limitations Exceptions &
Common Medical Event	Services You May Need	(You will pay the least)	(You will pay the most)	Other Important Information
	Primary care visit to treat an iniury	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
If you visit a health care provider's office or clinic			No charge for adult preventive	You may have to pay for services that aren't <u>preventive</u> .
provider s office of clinic	Preventive care/screening/ immunization	No charge	<u>services</u> No charge for well-child care services	Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% <u>coinsurance</u>	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition. A retail pharmacy is any	Preferred generic drugs	\$10.00 <u>copay</u> /retail \$30.00 <u>copay</u> /mail service \$30.00 <u>copay</u> /90dayRx retail	Not covered	Covers up to a 31-day supply (retail prescription). 90-day supply (mail order
licensed pharmacy that you can physically enter to obtain a <u>prescription drug</u> . A mail	Preferred brand drugs	\$25.00 <u>copay</u> /retail \$75.00 <u>copay</u> /mail service \$75.00 <u>copay</u> /90dayRx retail	Not covered	prescription and 90dayRx retail prescription). Some over-the-counter drugs
service pharmacy dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is available at	ġ	Non-preferred generic drugs: \$10.00 <u>copay</u> /retail \$30.00 <u>copay</u> /mail service \$30.00 <u>copay</u> /90dayRx retail Non-preferred brand drugs: \$40.00 <u>copay</u> /retail	Non-preferred generic drugs: Not covered Non-preferred brand drugs: Not covered	can be obtained with a prescription at the <u>preventive</u> level of benefits. Insulin listed on the preferred generic/preferred brand <u>prescription drug</u> list are
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If you need help recovering		ff you are pregnant		behavioral health, or substance use services	If you need mental health,		If you have a hospital stay		If you need immediate medical attention		aniñei à	If you have outpatient		www.bluecrossmnonline.com
Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services including residential adult mental health treatment	Outpatient services	Physician/surgeon fee	Facility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	Specialty drugs	
20% coinsurance	20% <u>coinsurance</u>	20% coinsurance	Prenatal care: No charge Postnatal care: 20% <u>coinsurance</u>	20% coinsurance	20% <u>coinsurance</u>	20% coinsurance	20% <u>coinsurance</u>	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% <u>coinsurance</u>	Refer to applicable <u>prescription</u> drug <u>cost sharing</u>	\$120.00 <u>copay</u> /mail service \$120.00 <u>copay</u> /90dayRx retail
20% coinsurance	20% coinsurance	20% coinsurance	Prenatal care: No charge Postnatal care: 20% <u>coinsurance</u>	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	20% coinsurance	Not covered	
None	include tests and services described elsewhere in the SBC (i.e. ultrasound).	may apply. Maternity care may	<u>Cost sharing</u> does not apply for preventive services. Depending on the type of	None	Services for marriage/couples counseling are not covered.	None	None	None	None	None	None	None	Covers up to a 31-day supply (participating <u>specialty drug</u> <u>network</u> supplier prescription). The value of drug coupons you use will not count towards <u>cost-sharing</u> or <u>out-of-pocket</u> <u>limits</u> .	covered at zero <u>cost-sharing</u> .

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Your Rights to Continue Coverage: There agencies is: Minnesota Department of Comm G 10272392 Effective 04/01/2021_SBC_Version Effective 1/1/2021	Chiropractic care	 Bariatric surgery 	Other Covered Services (Lim	 Dental care (except as specified in plan benefits) 	 Cosmetic surgery (except as specified in plan benefits) 	 Acupuncture (except as specified in plan benefits) 	Services Your Plan Generally	Excluded Services & Oth		If your child needs dental or eye care						or have other special health needs
erage: There are agencies that c ment of Commerce, Attention: Co n Effective 1/1/2021 4 of 8	• Nor U.S	• Hea you	Other Covered Services (Limitations may apply to these services.	cified in plan benefits)	•	•	/ Does NOT Cover (Check your	Other Covered Services:	Children's dental check-up	Children's glasses	Children's eye exam	Hospice service	Durable medical equipment	Skilled nursing care	Habilitation services	Rehabilitation services
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: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-10272392 Effective 04/01/2021_SBC_Version Effective 11/2021_4 of 8	Non-emergency care when traveling outside U.S.	Hearing aids for individuals 18 year of age or younger	vices. This isn't a complete list. Please		Long-term care	Infertility treatment	Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more infor		Not covered	20% <u>coinsurance</u> Not covered	No charge	20% coinsurance	20% coinsurance	20% <u>coinsurance</u>	20% <u>coinsurance</u> for occupational therapy 20% <u>coinsurance</u> for physical therapy 20% <u>coinsurance</u> for speech therapy	20% <u>coinsurance</u> for occupational therapy 20% <u>coinsurance</u> for physical therapy 20% <u>coinsurance</u> for speech therapy
r coverage after it ends. The conta ce Division, 85 7th Place East Suit	utside the Routine eye care (adult)	age or 🔹 Private-duty nursing	Please see your <u>plan</u> document.)		 Weight loss programs 	 Routine foot care 	e information and a list of any other excluded services.)		Not covered	Not covered	No charge	Not covered	20% coinsurance	20% <u>coinsurance</u>	20% <u>coinsurance</u> for occupational therapy 20% <u>coinsurance</u> for physical therapy 20% <u>coinsurance</u> for speech therapy	20% <u>coinsurance</u> for occupational therapy 20% <u>coinsurance</u> for physical therapy 20% <u>coinsurance</u> for speech therapy
act information for those le 280, St. Paul, MN 55101-	e (adult)	gnis			grams	Ċ	other excluded services.)		None	None	None	None	None	Combined <u>in-network</u> and <u>out-of-network</u> : 120 days per benefit period.		Dopp

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G_10272392_Effective 04/01/2021_SBC_Version Effective 1/1/2021 5 of 8	 gender, you can tile a <u>grievance</u> with the Nondiscrimination Civil Rights Coordinator by email at: <u>Civil.Rights.Coord@bluecrossmn.com</u> 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 	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		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.	Does this <u>plan</u> meet Minimum Value Standards? Yes. If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u> , you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through MNsure/the <u>Marketplace</u> . Notice of Nondiscrimination Practices Effective July 18, 2016	Does this <u>plan</u> provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes <u>plans</u> , health insurance available through MNsure/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.	Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u> . This complaint is called a grievance or <u>appeal</u> . For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u> . Your <u>plan</u> documents also provide complete information to submit a <u>claim</u> , <u>appeal</u> , or a <u>grievance</u> for any reason to your <u>plan</u> . For more information about your rights, this notice, or assistance, contact: Customer Service at <u>www.bluecrossmnonline.com</u> or call 1-888-279-4210 or the Minnesota Department of Commerce by calling (651) 539-1600 or toll-free 1 800-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>https://www.dol.gov/agencies/ebsa/asbout-ebsa/ask-a-question/ask-ebsa</u> . If you are covered under a <u>plan</u> offered by the State Health <u>plan</u> , 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.	2198, or call 1 800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866- 444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa ; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ . Other coverage options may be available to you too, including buying individual insurance coverage through MNsure/the Marketplace . For more information about MNsure/the Marketplace, visit www.mnsure.org or call 1 855 366 7873.
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G_10272392_Effective 04/01/2021_SBC_Version Effective 1/1/2021 6 of 8	Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.	Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.	ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.	한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.	አማርኛ የሚናንሩ ከሆነ፣ ነጻ የቋንቋ አንልግሎት እርዳ አለሎት። በ ו-855-3ነ5-4030 ይደውሉ ለ ፐፐሃ በ 7ነነ።	использования телефонного аппарата с текстовым выходом звоните /11. Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.	如果您說中文,我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。曬語障專(ТТҮ),請撥打 711。 Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для	Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711. Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.	إذا كنت تتحدث المربية، تتوفر لك خدمات المساعة اللغوية المجانية. اتصل بالرقم 123-968-169- للهاتف النصي اتصل بالرقم 711.	နမ့်၊ကဘိ၊ကညီကိုဗိုဒီး. တါကဟုဉ်န၊ကိုာ်တါမ၊စ၊၊ကလိဇာဖဉ်နှုဉ်လိ၊. ကီး 1-866-251-6744 လ၊ TTYဆဂို. ကီး 711 တက်၊.	Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711. Haddii 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.	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.	This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.	Language Access Services:	200 Independence Avenue SW Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.	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	You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights	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.
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ប្រសិនឃើរក្ខានិយាយភាសាម្លែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតផ្ទៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

711 jį' béésh bee hodiilnih. Diné k'ehjí yánítt'igo saad bee yát'i' éi t'áajiík'e bee níká'a'doowołgo éí ná'ahoot'i'. Koji éi béésh bee hodiílnih 1-855-902-2583. TTY biniiyégo éí

To see examples of how this **plan** might cover costs for a sample medical situation, see the next page.-

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1146. The time required to complete this information collection is estimated to average 0.08 hours per response, including the time to review instructions, search existing data resources, gather data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Peg is Having a Baby (9 months of Department prenatal care and a hospital delivery)	and a	Managing Joe's type 2 Diabetes (a year of routine reserved, care of a well controlled condition)	2 Diabetes care of a well- on)	Mia's Simple Fracture (n-network emergency room visit and follow up care)	follow up
 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$500 \$0 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$500 \$0 20%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> copay Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$500 \$0 20% 20%
This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/delivery professional services	s like:	This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including</i> <i>disease education</i>)	ces like: luding	This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray)	al supplies)
Childbirth/delivery facility services <u>Diagnostic tests</u> (ultrasounds and blood work) <u>Specialist</u> visit (anesthesia)	vork)	Diagnostic tests (blood work) Prescription drugs Durable medical equipment (glucose meter)	on drugs leter)	Durable medical equipment (crutches) Rehabilitation services (physical therapy)	Z
Total Example Cost	\$12,700	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
Cost Sharing		Cost Sharing		Cost Sharing	
Deductibles	\$500	Deductibles	\$500	Deductibles	\$500
Copays	\$10	Copays	\$100	Copays	\$0
Coinsurance	\$1,000	ance	\$300	Coinsurance	\$400
What isn't covered		What isn't covered		What isn't covered	5
Limits or exclusions	\$60	Limits or exclusions	\$20	Limits or exclusions	0\$0
	\$1,570	The total Joe would pay is	\$920	The total Mia would pay is	006\$

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Blue Cross[®] and Blue Shield[®] of Minnesota and Blue Plus[®] are nonprofit independent licenases of the Blue Cross and Blue Shield Association

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1-866-873-5943. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossmnonline.com or call toll-free the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

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Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care, prenatal care and in-network preventive care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$3,500 individual medical and drug combined <u>in-network</u> and <u>out-of-network</u> \$7,000 family medical and drug combined <u>in-network</u> and <u>out-of-network</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-</u> <u>of-pocket limit</u> ?	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 an in-network provider?	Yes. See https://www.bluecrossmnonline.com/find- a-doctor#/home or call toll-free 1-866-	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network</u> <u>provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what

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		What you	Mill Pay	
Common Medical Event	Services You May Need	What you W In-network Provider (You will pay the least)	Will Pay Out-of-memory Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an iniury	0% coinsurance	0% coinsurance	None
	Specialist visit	0% coinsurance	0% coinsurance	None
lf you visit a health care <u>provider's</u> office or clinic	Preventive care/screening/ immunization	No charge	No charge for adult <u>preventive</u> <u>services</u> No charge for well-child care services	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
lf vou have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	0% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	0% coinsurance	
If you need drugs to treat your illness or condition.	Preferred generic drugs	0% <u>coinsurance</u> /retail 0% <u>coinsurance</u> /mail service 0% <u>coinsurance</u> /90dayRx retail	Not covered	Covers up to a 31-day supply (retail prescription). 90-day supply (mail order
A retail pharmacy is any licensed pharmacy that you can physically enter to obtain	Preferred brand drugs	0% <u>coinsurance</u> /retail 0% <u>coinsurance</u> /mail service 0% <u>coinsurance</u> /90dayRx retail	Not covered	prescription and 90dayRx retail prescription). No coverage for non-preferred
a prescription drug. A mail service pharmacy dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is available at www.bluecrossmnonline.com	Non-preferred drugs		Non-preferred generic drugs: Not covered Non-preferred brand drugs: Not covered	Some over-the-counter drugs can be obtained with a prescription at the <u>preventive</u> level of benefits. Insulin listed on the preferred generic/preferred brand <u>prescription drug</u> list are

Do you need a referral to see a

No.

You can see the specialist you choose without a referral.

before you get services.

your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>in-network provider</u> might use an <u>out-of-</u><u>network provider</u> for some services (such as laboratory work). Check with your <u>provider</u>

providers.

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If you need help recovering or have other special health needs			If you are pregnant		behavioral health, or substance use services	If you need mental health,		If you have a hospital stay		If you need immediate medical attention		Ainfine	If you have outpatient	
Rehabilitation services	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services including residential adult mental health treatment	Outpatient services	Physician/surgeon fee	Facility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	<u>Specialty drugs</u>
0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy 0% <u>coinsurance</u> for speech therapy	0% coinsurance	0% coinsurance	0% coinsurance	Prenatal care: No charge Postnatal care: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	Refer to applicable <u>prescription</u> drug cost sharing
0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy 0% <u>coinsurance</u> for speech therapy	0% coinsurance	0% coinsurance	0% coinsurance	Prenatal care: No charge Postnatal care: 0% <u>coinsurance</u>	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	Not covered
None	None	include tests and services described elsewhere in the SBC (i.e. ultrasound).	services, other <u>cost sharing</u> may apply. Maternity care may	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of	None	Services for marriage/couples counseling are not covered.	None	None	None	None	None	None	None	Covers up to a 31-day supply (participating <u>specialty drug</u> <u>network</u> supplier prescription). The value of drug coupons you use will not count towards <u>cost-sharing</u> or <u>out-of-pocket</u> <u>limits</u> .

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Your (arievar	Your F agenci 2198, (444-EE Informa options Market	<u>•</u>	• Ba	Other	• De	• bei	• Aci	Servic	Exclu	eye care	IT YOUR C						3.8
brievance and Appeals nce or appeal. For more	tights to Continue Cov es is: Minnesota Depart or call 1 800-657-3602; t 3SA (3272) or https://ww ation and Insurance Ove that ion and Insurance Ove may be available to yo place, visit www.mnsure	Chiropractic care	Bariatric surgery	Covered Services (Lim	Dental care (except as specified in plan benefits)	Cosmetic surgery (except as specified in plan benefits)	Acupuncture (except as specified in plan benefits)	es Your <u>Plan</u> Generally	ded Services & Oth		If your child needs dental or						
Rights: There are agencies that information about your rights, lool	erage: There are agencies that ca ment of Commerce, Attention: Cor for group health coverage subject <u>ww.dol.gov/agencies/ebsa/about-e</u> rsight at 1-877-267-2323, extensi u too, including buying individual i u too, including buying findividual i	• Non U.S.	• Hea	itations may apply to these ser	cified in plan benefits)	•	•	Services Your Plan Generally Does NOT Cover (Check your policy or	Excluded Services & Other Covered Services:	Children's dental check-up	Children's glasses	Children's eye exam	Hospice service	Durable medical equipment	Skilled nursing care		Habilitation services
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> 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	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: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-2198, or call 1 800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa ; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ . Other coverage options may be available to you too, including buying individual insurance coverage through MNsure/the Marketplace . For more information about MNsure/the Marketplace. For more information about MNsure/the Marketplace. Visit www.mnsure.org or call 1 855 366 7873.	Non-emergency care when traveling outside the U.S.	Hearing aids for individuals 18 year of age or vounger	Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please		Long-term care	Infertility treatment	policy or <u>plan</u> document for more infor		Not covered	20% coinsurance	No charge	0% coinsurance	20% coinsurance	0% coinsurance	0% <u>coinsurance</u> for speech therapy	0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy
igainst your <u>plan</u> for a denial of a <u>c</u> u will receive for that medical <u>claim</u>	r coverage after it ends. The cont ce Division, 85 7th Place East Sui t of Labor's Employee Benefits Sec Department of Health and Human <u>CCIIO/Resources/Consumer-Assis</u> re/the <u>Marketplace</u> . For more infor	outside the Routine eye care (adult)	age or Private-duty nursing	Please see your <u>plan</u> document.)		 Weight loss programs 	 Routine foot care 	re information and a list of any o		Not covered	20% coinsurance	No charge	Not covered	20% coinsurance	0% <u>coinsurance</u>	0% <u>coinsurance</u> for speech therapy	0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy
<u>claim</u> . This complaint is called a <u>n</u> . Your <u>plan</u> documents also	act information for those ite 280, St. Paul, MN 55101- curity Administration at 1-866- Services, Center for Consumer stance-Grants/. Other coverage rmation about MNsure/the	re (adult)	rsing	t)		ograms	ē	mation and a list of any other excluded services.)		None	None	None	None	None	Combined <u>in-network</u> and <u>out-</u> <u>of-network</u> : 120 days per benefit period.		

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G_10272393_Effective 04/01/2021_SBC_Version Effective 1/1/2021 5 of 7	 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 	 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 <u>grievance</u> with the Nondiscrimination Civil Rights Coordinator by email at: <u>Civil.Rights.Coord@bluecrossmn.com</u> by mail at: <u>Nondiscrimination Civil Rights Coordinator</u> 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 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 <u>grievance</u>, assistance is available by contacting us at the numbers listed above. 	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.	 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 	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.	Does this <u>plan</u> meet Minimum Value Standards? Yes. If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u> , you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through MNsure/the <u>Marketplace</u> . Notice of Nondiscrimination Practices Effective July 18, 2016	Does this plan provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes plans, health insurance available through MNsure/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.	provide complete information to submit a <u>claim</u> , <u>appeal</u> , or a <u>grievance</u> for any reason to your <u>plan</u> . For more information about your rights, this notice, or assistance, contact: Customer Service at <u>www.bluecrossmnonline.com</u> or call 1-888-279-4210 or the Minnesota Department of Commerce by calling (651) 539-1600 or toll-free 1 800-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</u> . If you are covered under a <u>plan</u> offered by the State Health <u>plan</u> , 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.
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	The total Mia would pay is	\$2,320	The total Joe would pay is	\$3,560	The total Peg would pay is
	Limits or exclusions	\$20	Limits or exclusions	\$60	Limits or exclusions
What isn't covered	Wha		What isn't covered	•	What isn't covered
	Coinsurance	\$0	Coinsurance	\$0	Coinsurance
	Copays	\$0	Copays	\$0	Copays
\$2,800	Deductibles	\$2,300	Deductibles	\$3,500	Deductibles
Cost Sharing			Cost Sharing		Cost Sharing
ia would pay:	In this example, Mia would pay:		In this example, Joe would pay:		In this example, Peg would pay:
st \$2,800	Total Example Cost	\$5,600	Total Example Cost	\$12,700	Total Example Cost
This EXAMPLE event includes services like: Emergency room care (including medical supplies) Diagnostic test (x-ray) Durable medical equipment (crutches)	This EXAMPLE event includes servi Emergency room care (including medi Diagnostic test (x-ray) Durable medical equipment (crutches)	luding ion drugs	This EXAMPLE event includes services like: <u>Primary care physician</u> office visits (<i>including</i> <i>disease education</i>) <u>Diagnostic tests</u> (<i>blood work</i>) <u>Prescription drugs</u>	ces like:	This EXAMPLE event includes services like: <u>Specialist</u> office visits (<i>prenatal care</i>) Childbirth/delivery professional services Childbirth/delivery facility services
l <u>deductible</u> \$3,500 \$0 <u>coinsurance</u> 0% <u>e</u> 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist</u> copay Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,500 \$0 0%	 The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u> 	\$3,500 \$0 0%	The <u>plan's</u> overall <u>deductible</u> <u>Specialist copay</u> Hospital (facility) <u>coinsurance</u> Other <u>coinsurance</u>
Mia's Simple Fracture emergency room visit and follow up care)	Mia's (<u>n-natwork</u> emer	2 Diabetes care of a well- on)	Managing Joe's type 2 Diabetes (a year of routine the structure of a well controlled condition)	are and a	Peg is Having a Baby (9 months ofprenatal care and a hospital delivery)

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Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

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Coverage Period: Beginning on or after 04/01/2021

Coverage for: Individual/Family | Plan Type: HSA



1-866-873-5943. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.bluecrossmnonline.com or call toll-free the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. 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

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$6,350 individual medical and drug combined <u>in-network</u> and <u>out-of-network</u> \$12,700 family medical and drug combined <u>in-network</u> and <u>out-of-network</u>	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. Well-child care, prenatal care and in-network preventive care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copay</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <u>https://www.healthcare.gov/coverage/preventive-care-benefits/</u> .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	\$6,350 individual medical and drug combined in-network and out-of-network \$12,700 family medical and drug combined in-network and out-of-network	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket</u> <u>limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-</u> <u>of-pocket limit</u> ?	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 an in-network provider?	Yes. See https://www.bluecrossmnonline.com/find- a-doctor/#/home or call toll-free 1-866-	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> <u>network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the provider's charge and what

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Service pharmacy dispenses prescription drugs through the U.S. Mail.	A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a proscription drug A mail			If you have a test work)	If you visit a health care provider's office or clinic Preventive ca immunization	Specialist visit	Primary car injury	Common Medical Event Services		All copay and coinsurance costs	Do you need a referral to see a No.
Non-preferred drugs	rand drugs	Preferred generic drugs	Imaging (CT/PET scans, MRIs)	<u>Diagnostic test</u> (x-ray, blood work)	<u>Preventive care/screening/</u> immunization	isit	Primary care visit to treat an injury	Services You May Need		shown in this chart a	
Non-preferred generic drugs: 0% <u>coinsurance</u> /retail 0% <u>coinsurance</u> /mail service 0% <u>coinsurance</u> /90dayRx retail Non-preferred brand drugs: 0% <u>coinsurance</u> /retail	0% <u>coinsurance</u> /retail 0% <u>coinsurance</u> /mail service 0% <u>coinsurance</u> /90dayRx retail	0% <u>coinsurance</u> /retail 0% <u>coinsurance</u> /mail service 0% <u>coinsurance</u> /90dayRx retail	0% coinsurance	0% coinsurance	No charge	0% coinsurance	0% coinsurance	(You will pay the least)	What you W	All copay and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.	You can see the sp
Non-preferred generic drugs: Not covered Non-preferred brand drugs: Not covered	Not covered	Not covered	0% coinsurance	0% coinsurance	No charge for adult <u>preventive</u> services No charge for well-child care services	0% coinsurance	0% coinsurance	Out-of-network Provider (You will pay the most)	u Will Pay	ı met, if a <u>deductible</u> applies.	You can see the specialist you choose without a referral.
can be obtained with a prescription at the <u>preventive</u> level of benefits. Insulin listed on the preferred generic/preferred brand <u>prescription drug</u> list are covered at zero cost-sharing.	prescription and 90dayRx retail prescription). Some over-the-counter drugs	Covers up to a 31-day supply (retail prescription).		None	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.	None	None	Other Important Information	Limitations Examplians 2		<u>arral</u> .

873-5943 for a list of in-network

your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>in-network provider</u> might use an <u>out-of-</u><u>network provider</u> for some services (such as laboratory work). Check with your <u>provider</u>

before you get services.

providers.

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If you need help recovering or have other special health needs			If you are pregnant		behavioral health, or substance use services	If you need mental health,		If you have a hospital stay		If you need immediate medical attention		Alafine	If you have outpatient	
Rehabilitation services	Home health care	Childbirth/delivery facility services	Childbirth/delivery professional services	Office visits	Inpatient services including residential adult mental health treatment	Outpatient services	Physician/surgeon fee	Facility fee (e.g., hospital room)	Urgent care	Emergency medical transportation	Emergency room care	Physician/surgeon fees	Facility fee (e.g., ambulatory surgery center)	<u>Specialty drugs</u>
0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy 0% <u>coinsurance</u> for speech therapy	0% coinsurance	0% coinsurance	0% coinsurance	Prenatal care: No charge Postnatal care: 0% <u>coinsurance</u>	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	Refer to applicable <u>prescription</u> <u>drug cost sharing</u>
0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy 0% <u>coinsurance</u> for speech therapy	0% coinsurance	0% coinsurance	0% coinsurance	Prenatal care: No charge Postnatal care: 0% <u>coinsurance</u>	0% <u>coinsurance</u>	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	0% coinsurance	Not covered
None	None	include tests and services described elsewhere in the SBC (i.e. ultrasound).	services, other <u>cost sharing</u> may apply. Maternity care may	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of	None	Services for marriage/couples counseling are not covered.	None	None	None	None	None	None	None	Covers up to a 31-day supply (participating <u>specialty drug</u> <u>network</u> supplier prescription). The value of drug coupons you use will not count towards <u>cost-sharing</u> or <u>out-of-pocket</u> <u>limits</u> .

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our Grievance and Appeals rievance or appeal. For more	Your Rights to Continue Coverage: There are agencies tagencies is: Minnesota Department of Commerce, Attentio 2198, or call 1 800-657-3602; for group health coverage su 444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/ab Information and Insurance Oversight at 1-877-267-2323, e options may be available to you too, including buying indiviorations may be available to you too.	Chiropractic care	Bariatric surgery	ther Covered Services (Lim	Dental care (except as specified in plan benefits)	Cosmetic surgery (except as specified in plan benefits)	Acupuncture (except as specified in plan benefits)	ervices Your <u>Plan</u> Generally	Excluded Services & Other Covered Services:	eye care	If your child needs dental or							
Rights: There are agencies that information about your rights, lool	erage: There are agencies that comment of Commerce, Attention: Cour or group health coverage subject ww.dol.gov/agencies/ebsa/about-e rsight at 1-877-267-2323, extensi u too, including buying individual i u too all 1 855 366 7873.	• Non U.S	• Hea	itations may apply to these ser	cified in plan benefits)	•	•	Does NOT Cover (Check your	er Covered Services:	Children's dental check-up	Children's glasses	Children's eye exam	Hospice service	Durable medical equipment	Skilled nursing care		Habilitation services	
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u> . This complaint is called a grievance or <u>appeal</u> . For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u> . Your <u>plan</u> documents also	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: Minnesota Department of Commerce, Attention: Consumer Concerns/Market Assurance Division, 85 7th Place East Suite 280, St. Paul, MN 55101-2198, or call 1 800-657-3602; for group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa ; or, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ . Other coverage options may be available to you too, including buying individual insurance coverage through MNsure/the Marketplace . For more information about MNsure/the Marketplace. For more information about MNsure/the Marketplace. Visit www.mnsure.org or call 1 855 366 7873.	younger Non-emergency care when traveling outside the U.S.	Hearing aids for individuals 18 year of age or	Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please		Long-term care	Infertility treatment	Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more inform		Not covered	20% coinsurance	No charge	0% coinsurance	20% coinsurance	0% coinsurance	0% coinsurance for speech therapy	0% <u>consurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy	nov anisationan for
gainst your <u>plan</u> for a denial of a <u>c</u> ı will receive for that medical <u>claim</u>	Ir coverage after it ends. The contact information for those ce Division, 85 7th Place East Suite 280, St. Paul, MN 5510 of Labor's Employee Benefits Security Administration at 1-4 Department of Health and Human Services, Center for Cons CIIO/Resources/Consumer-Assistance-Grants/. Other cove re/the Marketplace. For more information about MNsure/the	utside the Routine eye care (adult)	age or Private-duty nursing	Please see your <u>plan</u> document.)		 Weight loss programs 	 Routine foot care 	re information and a list of any c		Not covered	20% coinsurance	No charge	Not covered	20% coinsurance	0% coinsurance	0% <u>coinsurance</u> for speech therapy	0% <u>coinsurance</u> for occupational therapy 0% <u>coinsurance</u> for physical therapy	
<u>claim</u> . This complaint is called a <u>n</u> . Your <u>plan</u> documents also	act information for those te 280, St. Paul, MN 55101- curity Administration at 1-866- Services, Center for Consumer tance-Grants/. Other coverage rmation about MNsure/the	re (adult)	rsing	r)		ograms	ē	mation and a list of any other excluded services.)		None	None	None	None	None	Combined <u>in-network</u> and <u>out-of-network</u> : 120 days per benefit period.			

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 Erguish. 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 <u>grievance</u> with the Nondiscrimination Civil Rights Coordinator by email at: <u>Civil.Rights.Coord@bluecrossmn.com</u> by mail at: Nondiscrimination Civil Rights Coordinator Blue Cross and Blue Shield of Minnesota and Blue Plus - M495 po Box 64560 or by telephone at: 1-800-503-2312 <u>Grievance</u> 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 <u>grievance</u>, 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: <u>https://ocrportal.hts.gov/ocr/portal/lobby.isf</u> 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 W 200 Independence Avenue W gri 	 provide compresent more source activity of <u>surface construction</u> or <u>call</u> 1-888-2794/210 or the Minnesota Department of Commerce by Lealing (651) 539-1600 or belified or belified 533-2769. B00-657-3602. For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <u>https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa</u>. If you are covered under a <u>plan</u> offered by the State Health <u>plan</u>, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 1-886-333-2789. Does this <u>plan</u> provide Minimum Essential Coverage? Yes. Minimum Essential Coverage generally includes <u>plans</u>, health insurance available through MNsure/the <u>Marketplace</u> or other individual market policies, Medicare, Medicard, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of <u>Minimum Essential Coverage</u>, you may not be eligible for the premium tax credit. Does this <u>plan</u> meet Minimum Value Standards? Yes. If your <u>plan</u> doesn't meet the <u>Minimum Value Standards</u>, you may be eligible for a <u>premium tax credit</u> to help you pay for a <u>plan</u> through MNsure/the <u>Marketplace</u>. Notice of Nondiscrimination Practices Effective July 18, 2016 Bue 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. Auxiliary aids and services, such as qualified interpreters and information written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us. Language servic
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To see examples of how this plan might cover costs for a sample medical situation, see the next page. PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attr: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.
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Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.
ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໃຫຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໃຫຫາ 711.
한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.
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использования телефонного аппарата с текстовым выходом звоните / ГТ. Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.
слугами переводчи
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Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711. A tran Oromoo dubbattu voo ta'a taiaailla naroaarsa afaan hiikuu kaffaltii malee. Aroachuuf 1-855-315-4016 bilbilaa. TTY dhaaf. 711 bilbilaa.
إذا كنت تتحدث العربية، تتوفر لك خدمات المساحة اللغوية المجانية. اتصل بالرقم 123-866-569-912. للهاتف النصي اتصل بالرقم 711.
နမ့်၊ကတိၤကညီကိုာ်ဒီး. တ၊်ကဟ့ဉ်နု၊ကိုာ်တ၊်မာစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTY ဆဂိၤ. ကိး 711 တက္İ.
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Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.
This information is available in other languages. Free language assistance services are available by calling the follower formations is the company of the follower of the company of the
Room 509F, HHH Building Washington, DC 20201

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