The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, including a copy of your plan's summary plan description, go to www.speiasc.org. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.www.cciio.cms.gov

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750** person / **$1,500** family for each network and non-network providers.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there services covered before you meet your deductible?	Yes. **Preventive care services**, Prescription Drugs, Allergy testing, Durable Medical Equipment and certain Transplants are covered before you meet your deductible, if provided by a Network Provider.	This plan covers some items and services even if you haven't yet met the annual **deductible** amount, but a **copayment** or **coinsurance** may apply. For example, this plan covers certain **preventive services** without cost-sharing and before you meet your deductible. See a list of covered **preventive services** at https://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
What is the out-of-pocket limit for this plan?	Network Medical: **$1,500** person / **$3,000** family; Non-Network Medical **$3,000** person / **$6,000** family. Prescription Out-of-Pocket Limit: **$5,650** person / **$11,300** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See www.bluelinktpamn.com or call 1-800-810-2583 for help in locating a network provider.	This **plan** uses a network provider. You will pay less if you use a provider in the **plan's** network. You will pay more if you use an **out-of-network provider**, and you might receive a bill from the **out-of-network** provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an **out-of-network** provider for some services (such as lab work). For **out-of-network** charges, the Plan's Allowed Amount is set at the lesser of the amount billed or 175% of Medicare Like Rates. Check with your provider before you get services.
Do you need a referral to see a specialist?	No. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% **coinsurance;** No charge for Doctor on Demand telehealth visits	40% **coinsurance**	Acupuncture must be provided by chiropractor or licensed Acupuncturist; limited to treatment for chronic pain and nausea associated with surgery, chemotherapy, or pregnancy. Maximum of 26 visits per year for chiropractic and acupuncture care.
	Specialist visit	20% **coinsurance**	40% **coinsurance**	——————none——————
	Preventive care/screening/ immunization	No charge	40% **coinsurance**	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your **plan** will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% **coinsurance**	40% **coinsurance**	——————none——————
	Imaging (CT/PET scans, MRIs)	20% **coinsurance**	40% **coinsurance**	For a pregnancy, two ultrasounds are covered 100% as preventive care; additional ultrasounds may be subject to coinsurance. Includes one diagnostic breast cancer

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)	
				mammogram, if medically necessary, per year at no charge (in addition to one breast cancer screening mammogram per year); additional breast cancer mammograms are subject to **coinsurance**.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.myprime.com	Formulary Drugs	Greater of $8 (retail 31-day) **copay** or 20%. Or, $16 (mail order/ retail 90-day) **copay** or 20%	Greater of $8 **copay** or 20% plus difference between negotiated rate and charge per drug (retail)	Covers up to a 31-day supply (retail); 31-90 day supply (mail order/retail). **Copay** capped at $100 (retail/31 day) / $200 (mail order/retail 90-day) per drug. No coverage for non-network mail-order prescriptions. May be subject to Prior Authorization, Step Therapy and Quantity Limits. Dispensed through the Classic Pharmacy network – go to www.myprime.com
	Non-Formulary Drugs	No coverage	No coverage	——————none——————
	Prescribed PPI/NSAH Over-the-Counter (OTC) Drugs	No charge	No coverage	——————none——————
	Specialty drugs	Greater of $8 (retail 31-day) **copay** or 20%. Or, $16 (mail order/retail 90-day) **copay** or 20%	No coverage	**Copay** capped at $100 (retail/31 day) / $200 (mail/retail 90-day order) per drug. Not subject to **out-of-pocket limit**.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% **coinsurance**	40% **coinsurance**	——————none——————
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	——————none——————
If you need immediate medical attention	Emergency room care	$100 **copay** per visit & 20% **coinsurance**	$100 **copay** per visit & 20% **coinsurance**	**Copay** is not charged if admitted.
	Emergency medical transportation	20% **coinsurance**	20% **coinsurance**	——————none——————
	Urgent care	20% **coinsurance**	40% **coinsurance**; No charge for Doctor on Demand telehealth visits	——————none——————

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 have a hospital stay	Facility fee (e.g., hospital room)	20% **coinsurance**	40% **coinsurance**	Private rooms covered only if medically necessary.
	Physician/surgeon fees	20% **coinsurance**	40% **coinsurance**	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% **coinsurance**	40% **coinsurance**	Services must be provided by agencies meeting certain qualifications. See **plan** for additional requirements and exceptions.
	Inpatient services			
If you are pregnant	Office visits	No charge	40% **coinsurance**	Cost sharing does not apply to certain preventive services. Two ultrasounds are covered 100% as **preventive care**; additional ultrasounds are subject to **coinsurance**. Depending on the type of services or lab work, **coinsurance** may apply. Maternity care may include tests and services described elsewhere in the SBC).
	Childbirth/delivery professional services	20% **coinsurance**	40% **coinsurance**	
	Childbirth/delivery facility services	20% **coinsurance**	40% **coinsurance**	
If you need help recovering or have other special health needs	Home health care	20% **coinsurance**	40% **coinsurance**	Prior authorization required. Services must be provided by a Medicare-certified home health agency. See **plan** for additional requirements and exceptions.
	Rehabilitation services	20% **coinsurance**	40% **coinsurance**	Excludes activities of daily living. Prior authorization required after 12 visits.
	Habilitation services	20% **coinsurance**	40% **coinsurance**	Excludes activities of daily living Prior authorization required after 12 visits.
	Skilled nursing care	20% **coinsurance**	40% **coinsurance**	Prior authorization required Confinement must begin within 30 days of discharge from hospital for same or related illness.
	Durable medical equipment	20% **coinsurance**, no **deductible**	20% **coinsurance**, no **deductible**	Prior authorization required certain specific equipment. Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	20% **coinsurance**	No coverage	Prior authorization required.

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 your child needs dental or eye care	Children's eye exam	No charge	Plan provides $200 allowance per year, otherwise no coverage	Limited to one exam per year. Benefit provided through Vision Service Plan, www.vsp.com. or 800-877-7195.
	Children's glasses	No charge for lenses, $150 allowance for frames of choice, or $170 allowance for featured frame brands, or $80 allowance for Costco frames	$200 allowance per year, otherwise no coverage	20% off the amount over allowance for frames. Benefit provided through Vision Service Plan, www.vsp.com or 800-877-7195.
	Children's dental check-up	No charge	Coverage is capped at In-network Allowed Amount, so there may be a balance bill	Go to www.deltadentalmn.org for a list of participating providers.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

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

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

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

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-696-6775 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also

provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 651-776-4239 or www.speiacs.org.

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

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

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 952-835-3035 or 800-247-0401

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 952-835-3035 or 800-247-0401

Chinese (中文): 如果需要中文的帮助， **请拨打这个号码** 952-835-3035 or 800-247-0401

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 952-835-3035 or 800-247-0401

Hmong (Hmong): Kev pab nyob rau hauv Hmong, thov hu rau: 952-835-3035 or 800-247-0401

Somali (Soomaali): Wixii caawimaad ah ee Soomaaliya, fadlan wac: 952-835-3035 or 800-247-0401

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

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$750
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$10,000**

In this example, Peg would pay:

	Cost Sharing	
Deductibles	Deductibles	$750
Copayments	Copayments	$800
Coinsurance	Coinsurance	$670
	What isn't covered	
Limits or exclusions	Limits or exclusions	$
The total Peg would pay is	**The total Joe would pay is**	**$2,220**

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

The plan's overall deductible	$750
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$4,900**

In this example, Joe would pay:

	Cost Sharing	
Deductibles	Deductibles	$750
Copayments	Copayments	$800
Coinsurance	Coinsurance	$670
	What isn't covered	
Limits or exclusions	Limits or exclusions	$
The total Joe would pay is	**The total Joe would pay is**	**$2,220**

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

The plan's overall deductible	$750
Specialist *[cost sharing]*	20%
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$6,100**

In this example, Mia would pay:

	Cost Sharing	
Deductibles		$750
Copayments		$80
Coinsurance		**$1,050**
	What isn't covered	
Limits or exclusions		**$**
The total Mia would pay is		**$1,500**

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

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