CSB/SJU/OSB: High Deductible Health Plan with HSA

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

Coverage Period: Beginning on or after 07/01/2018
Coverage for: Single and family | Plan Type: HSA

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 www.bluecrossmnonline.com or call 1-866-873-5943. 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 or call 1-866-873-5943 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>$2,700/individual medical and drug Network $5,200/family medical and drug Network $2,700/individual medical and drug Out-of-Network $5,200/family medical and drug Out-of-Network</td>
<td>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. 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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Well-child care, prenatal care and Network Preventive care services are covered before you meet your deductible.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>$2,700/individual medical and drug Network $5,200/family medical and drug Network $3,600/individual medical and drug Out-of-Network $7,200/family medical and drug Out-of-Network</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a <strong>network provider</strong>?</td>
<td>Yes. See <a href="http://www.bluecrossmnonline.com">www.bluecrossmnonline.com</a> or call 1-866-873-5943 for a list of network providers.</td>
<td>This plan uses a <strong>provider network</strong>. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Do you need a <strong>referral</strong> to see a <strong>specialist</strong>?</td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

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>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>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>0% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>0% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition. A Retail Pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A Mail Service Pharmacy dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is available at</td>
<td>Preferred generic drugs</td>
<td>0% coinsurance/retail 0% coinsurance/mail service 0% coinsurance/90dayRx Retail</td>
<td>Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription and 90dayRx Retail prescription). No coverage for mail order or 90dayRx Retail drugs from out-of-network providers.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>0% coinsurance/retail 0% coinsurance/mail service 0% coinsurance/90dayRx Retail</td>
<td>0% coinsurance/retail Not covered mail order or 90dayRx Retail drugs</td>
</tr>
<tr>
<td></td>
<td>Non-preferred drugs</td>
<td>0% coinsurance/retail 0% coinsurance/mail service 0% coinsurance/90dayRx Retail</td>
<td>0% coinsurance/retail Not covered mail order or 90dayRx Retail drugs</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
<td>------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><a href="http://www.bluecrossmnonline.com">www.bluecrossmnonline.com</a></td>
<td>Specialty drugs</td>
<td>Refer to applicable prescription drug <strong>cost sharing</strong></td>
<td>Not covered</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>0% <strong>coinsurance</strong></td>
<td>0% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>0% <strong>coinsurance</strong></td>
<td>0% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal Care: No charge</td>
<td>Prenatal Care: 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Postnatal Care: 0% <strong>coinsurance</strong></td>
<td>Postnatal Care: 20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>0% <strong>coinsurance</strong></td>
<td>20% <strong>coinsurance</strong></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>0% <strong>coinsurance</strong> for occupational therapy</td>
<td>20% <strong>coinsurance</strong> for occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% <strong>coinsurance</strong> for physical therapy</td>
<td>20% <strong>coinsurance</strong> for physical therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>0% <strong>coinsurance</strong> for speech therapy</td>
<td>20% <strong>coinsurance</strong> for speech therapy</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>0% <strong>coinsurance</strong> for occupational therapy</td>
<td>20% <strong>coinsurance</strong> for occupational therapy</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></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td>0% coinsurance for physical therapy</td>
<td>20% coinsurance for physical therapy</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td>0% coinsurance for speech therapy</td>
<td>20% coinsurance for speech therapy</td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td>0% coinsurance</td>
<td>20% coinsurance</td>
</tr>
</tbody>
</table>

**If your child needs dental or eye care**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic Surgery (except as specified in plan benefits)</td>
</tr>
<tr>
<td>• Dental Care (except as specified in plan benefits)</td>
</tr>
<tr>
<td>• Hearing Aids</td>
</tr>
<tr>
<td>• Infertility Treatment</td>
</tr>
<tr>
<td>• Long-Term Care</td>
</tr>
<tr>
<td>• Private Duty Nursing</td>
</tr>
<tr>
<td>• Routine Eye Care (Adult)</td>
</tr>
<tr>
<td>• Routine Foot Care</td>
</tr>
<tr>
<td>• Weight Loss Programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture (except as specified in plan benefits)</td>
</tr>
<tr>
<td>• Bariatric Surgery</td>
</tr>
<tr>
<td>• Chiropractic Care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

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

**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.cciio.cms.gov. Other options to continue coverage 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.
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: your Claims Administrator by calling toll-free 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 888-393-2789.

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 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 MNsure/the Marketplace.

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)
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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

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.


Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaab caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 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, 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of network prenatal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan's overall deductible</strong></td>
<td>$2,700</td>
<td>$2,700</td>
</tr>
<tr>
<td><strong>Specialist copayment</strong></td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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** | $12,800 | $7,400 | $1,900

In this example, Peg would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,700</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions | $60 |
- The total Peg would pay is | $2,760 |

In this example, Joe would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,700</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions | $55 |
- The total Joe would pay is | $2,755 |

In this example, Mia would pay:

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Deductibles</th>
<th>Copayments</th>
<th>Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Copayments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions | $0 |
- The total Mia would pay is | $1,900 |

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Note: These numbers assume the patient does not participate in the plan’s wellness program. If you participate in the plan’s wellness program, you may be able to reduce your costs.

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