


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

**Coverage Period: Beginning on or after 01/01/2025**  
**Coverage for: Individual/Family | Plan Type: PPO**

 **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 [bluecrossmn.com](http://bluecrossmn.com) or call 1-844-348-0582. 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	Answers	Why this Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	\$1,650 individual / \$3,300 family medical and drug <a href="#">in-network</a> \$4,850 individual / \$9,700 family medical and drug <a href="#">out-of-network</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. This <a href="#">plan</a> has a non-embedded <a href="#">deductible</a> . If you have other family members on this <a href="#">plan</a> , the overall family <a href="#">deductible</a> must be met before the <a href="#">plan</a> begins to pay.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Well child care, prenatal care and <a href="#">in-network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this plan?</b>	\$6,000 individual / \$12,000 family medical and drug <a href="#">in-network</a> \$12,000 individual / \$24,000 family medical and drug <a href="#">out-of-network</a>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. This <a href="#">plan</a> has a non-embedded <a href="#">out-of-pocket limit</a> . If you have other family members on this <a href="#">plan</a> , the overall family <a href="#">out-of-pocket limit</a> must be met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billing</a> charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .

<p><b>Will you pay less if you use an <a href="#">in-network provider</a>?</b></p>	<p>Yes. Your <a href="#">network</a> is. Aware®. See <a href="http://bluecrossmn.com/find-a-doctor/#/home">bluecrossmn.com/find-a-doctor/#/home</a> or call 1-866-873-5943 for a list of <a href="#">in-network providers</a>.</p>	<p>This <a href="#">plan</a> uses a <a href="#">provider network</a>. You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a>. You will pay the most if you use an <a href="#">out-of-network provider</a>, and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (<a href="#">balance billing</a>). Be aware your <a href="#">in-network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.</p>
<p><b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b></p>	<p>No.</p>	<p>You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a>.</p>



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
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p><b>If you visit a health care <a href="#">provider's</a> office or clinic</b></p>	<p>Primary care visit to treat an injury or illness</p>	<p>20% <a href="#">coinsurance</a></p>	<p>40% <a href="#">coinsurance</a></p>	<p>None</p>
	<p><a href="#">Specialist</a> visit</p>	<p>20% <a href="#">coinsurance</a></p>	<p>40% <a href="#">coinsurance</a></p>	<p>None</p>
	<p><a href="#">Preventive care/screening/immunization</a></p>	<p>No charge</p>	<p>Well child: No charge Adult: 40% <a href="#">coinsurance</a></p>	<p>You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.</p>
<p><b>If you have a test</b></p>	<p><a href="#">Diagnostic test</a> (x-ray, blood work)</p>	<p>20% <a href="#">coinsurance</a></p>	<p>40% <a href="#">coinsurance</a></p>	<p>May require prior authorization.</p>
	<p>Imaging (CT/PET scans, MRIs)</p>	<p>20% <a href="#">coinsurance</a></p>	<p>40% <a href="#">coinsurance</a></p>	
<p><b>If you need drugs to treat your illness or condition.</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://bluecrossmn.com">bluecrossmn.com</a></p>	<p>Preferred generic drugs</p>	<p>\$10.00 <a href="#">copay</a>/prescription (retail) \$30.00 <a href="#">copay</a>/prescription (mail service) \$30.00 <a href="#">copay</a>/prescription (90dayRx retail)</p>	<p>Not covered</p>	<p>Covers up to a 31-day supply (retail prescription); 90-day supply (mail service prescription and 90dayRx retail prescription). You will pay no more than \$25 for a one-month supply for each prescription for eligible drugs to treat certain chronic diseases. You may need to meet your <a href="#">deductible</a> first. The value of drug coupons you use may count towards</p>
	<p>Preferred brand drugs</p>	<p>\$25.00 <a href="#">copay</a>/prescription (retail) \$75.00 <a href="#">copay</a>/prescription (mail service) \$75.00 <a href="#">copay</a>/prescription (90dayRx retail)</p>	<p>Not covered</p>	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred generic drugs	\$15.00 <a href="#">copay</a> /prescription (retail) \$45.00 <a href="#">copay</a> /prescription (mail service) \$45.00 <a href="#">copay</a> /prescription (90dayRx retail)	Not covered	<a href="#">cost sharing</a> or <a href="#">out-of-pocket limits</a> . Drugs and drug tiers on the formulary may change with notice. May require prior authorization.
	Non-preferred brand drugs	\$35.00 <a href="#">copay</a> /prescription (retail) \$105.00 <a href="#">copay</a> /prescription (mail service) \$105.00 <a href="#">copay</a> /prescription (90dayRx retail)	Not covered	
	<a href="#">Specialty drugs</a>	20% <a href="#">coinsurance</a> , up to a maximum of \$200	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	May require prior authorization.
	Physician/surgeon fees	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	May require prior authorization.
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	<a href="#">Out-of-network</a> services apply to the <a href="#">in-network deductible</a> and <a href="#">out-of-pocket limit</a> .
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a>	20% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-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% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	Physician/surgeon fee	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance use services	Outpatient services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services for marriage/couples counseling are not covered. May require prior authorization.
	Inpatient services including adult mental health treatment	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Services for marriage/couples counseling are not covered. May require prior authorization.
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: 20% <a href="#">coinsurance</a>	Prenatal care: No charge Postnatal care: 40% <a href="#">coinsurance</a>	<a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost-sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined 120 visits per person per benefit period. May require prior authorization.
	<a href="#">Rehabilitation services</a>	20% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	40% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	Occupational, physical, and speech therapy are limited to a combined limit of 15 visits per benefit period if you use an <a href="#">out-of-network provider</a> . May require prior authorization.
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	40% <a href="#">coinsurance</a> for occupational therapy, physical therapy, and speech therapy	
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	Combined 120 days per person per benefit period. May require prior authorization.

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	You will pay no more than \$50 per month for all eligible medical supplies to treat certain chronic diseases. You may need to meet your <a href="#">deductible</a> first. May require prior authorization.
	<a href="#">Hospice service</a>	20% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's eye exam	No charge	Age 0 through 5: No charge Age 6 through 18: 40% <a href="#">coinsurance</a>	None
	Children's glasses	Not covered	Not covered	No coverage for these services
	Children's dental check-up	Not covered	Not covered	No coverage for these services

#### 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](#).)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) (and children)
- Drugs not on the covered drug list unless an exception is obtained
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Routine foot care
- Weight loss programs

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

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Hearing aids
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform); or 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](http://www.cciio.cms.gov). For more information on your rights to continue coverage, contact Blue Cross at 1-866-873-5943. 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.mnsure.com](http://www.mnsure.com) or call 1-855-366-7873.

**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: Blue Cross at 1-866-873-5943; the Minnesota Department of Commerce at 1-800-657-3602; the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). If you are covered under a [plan](#) offered by the State Health Plan, a city, county, school district, or Service Cooperative, or church plan you may contact the Department of Health and Human Services Health Insurance team at 1-888-393-2789.

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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

#### **Does this plan Meet the Minimum Value Standards? 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 1-855-903-2583.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-537-7720.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-855-315-4017.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijijigo holne' 1-855-902-2583.

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

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About these Coverage Examples:



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

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

- The [plan's](#) overall [deductible](#) **\$1,650**
- [Specialist coinsurance](#) **20%**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

- [Specialist](#) office visits (*prenatal care*)
- Childbirth/delivery professional services
- Childbirth/delivery facility services
- [Diagnostic tests](#) (*ultrasounds and blood work*)
- [Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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**In this example, Peg would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,700
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$3,420</b>

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

- The [plan's](#) overall [deductible](#) **\$1,650**
- [Specialist coinsurance](#) **20%**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

- [Primary care physician](#) office visits (*including disease education*)
- [Diagnostic tests](#) (*blood work*)
- [Prescription drugs](#)
- [Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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**In this example, Joe would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$70
<a href="#">Coinsurance</a>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,840</b>

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

- The [plan's](#) overall [deductible](#) **\$1,650**
- [Specialist coinsurance](#) **20%**
- Hospital (facility) [coinsurance](#) **20%**
- Other [coinsurance](#) **20%**

**This EXAMPLE event includes services like:**

- [Emergency room care](#) (*including medical supplies*)
- [Diagnostic test](#) (*x-ray*)
- [Durable medical equipment](#) (*crutches*)
- [Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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**In this example, Mia would pay:**

<i>Cost Sharing</i>	
<a href="#">Deductibles</a>	\$1,650
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,860</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## Notice of Nondiscrimination and Accessibility

At Blue Cross and Blue Shield of Minnesota, we treat everyone fairly. We don't exclude you, or treat you less favorably, because of your race, skin color, national origin, age, disability status, or sex (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes). We follow federal civil rights laws and don't discriminate against anyone based on these traits.

If you communicate best in a language other than English, you can request free language assistance services.

If you have a vision, hearing, or speech impairment, we can communicate in a way that works best for you. This may include using sign language interpreters, providing documents in large print or Braille, audio recordings, or other aids at no charge.

**Need these services?** Call **1-855-903-2583**, TTY **711** or call the number on the back of your member identification card.

### Discrimination is against the law.

If we failed to provide services or discriminated in another way based on your race, skin color, national origin, age, disability status, or sex, (including sexual orientation; sex characteristics including intersex traits; pregnancy or related conditions; gender identity; and sex stereotypes), you can file a complaint by contacting our Nondiscrimination Civil Rights Coordinator:

**Email:** [Civil.Rights.Coord@bluecrossmn.com](mailto:Civil.Rights.Coord@bluecrossmn.com)  
**Telephone:** 1-800-509-5312  
**Mail:** Blue Cross and Blue Shield of  
Minnesota ATTN: Civil Rights  
Coordinator P3-2  
PO Box 64560, Eagan, MN 55164-0560

Nondiscrimination complaint forms are available on our website at [bluecrossmn.com/NDL](http://bluecrossmn.com/NDL), or from the Nondiscrimination Civil Rights Coordinator. You can also file a civil rights complaint with the U.S. Department of Health and Human Services

- electronically through the Office for Civil Rights complaint portal: [ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://ocrportal.hhs.gov/ocr/portal/lobby.jsf)
- by mail at: U.S. Department of Health and Human Services,  
200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201
- or by phone at: 1-800-368-1019, 1-800-537-7697 (TDD)

Civil rights complaint forms are available at [hhs.gov/ocr/office/file/index.html](http://hhs.gov/ocr/office/file/index.html).

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