BlueCross BlueShield Minnesota

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

CHS Inc. Consumer Directed Health Plan with HSA Option

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

Coverage Period:1/1/2020-12/31/2020

Coverage for: Single and family | **Plan Type:** CDHP

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 http://communications.bluecrossmn.com/chs or call 1-800-793-6932. For more information about your pharmacy coverage, visit www.express-scripts.com/chsinc or call 1-800-809-8616. 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:
What is the overall deductible?	**$1,400** for single coverage network **$2,800** for family coverage network **$2,800** for single coverage out of network **$5,600** for family coverage out of network Does not apply to preventive care services or prenatal care services from all providers.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The deductible must be met before applicable coinsurance is applied. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). This plan has a non-embedded deductible. For single plans, the plan begins paying benefits when the single deductible is met. For family plans, the plan begins paying benefits when the entire family deductible is met. The family deductible can be met by one or a combination of several family members.
Are there services covered before you meet your deductible?	Yes. Well-child care, prenatal care and Network Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there "other" deductibles for specific services?	No.	You don't have to meet "other" deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$3,425** medical and drug single coverage network **$6,850** medical and drug family coverage network **$6,850** medical and drug single coverage out of network **$13,700** medical and drug family coverage out of network	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, the overall family out-of-pocket limit has been met. The family out-of-pocket limit can be met by one or a combination of several family members.

What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See http://communications.bluecrossmn.com/chs or call 1-800-793-6932 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	40% coinsurance	None 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.
	Specialist visit	20% coinsurance	40% coinsurance	
	Preventive care/screening/ immunization	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRI's)	20% coinsurance	40% coinsurance	
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	Generic	20% coinsurance- retail 20% coinsurance- mail	20% coinsurance-retail No coverage for mail order drugs	No coverage for mail order drugs from Out-of-Network providers.
	Brand	20% coinsurance- retail 20% coinsurance- mail	20% coinsurance-retail No coverage for mail order drugs	
	Non Formulary	20% coinsurance- retail 20% coinsurance- mail	20% coinsurance-retail No coverage for mail order drugs	No coverage for services from Out-of-Network Providers.
	Specialty drugs	20% coinsurance- retail	No coverage	No coverage for services from Out-of-Network Providers.

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	
prescription drug coverage is available at www.express-scripts.com/chsinc.				
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	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	None
	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 for marriage/couples counseling are not covered.
	Inpatient services	20% coinsurance	40% coinsurance	
If you are pregnant	Office visits	Prenatal Care: No charge Postnatal Care: No charge	Prenatal Care: No charge Postnatal Care: no charge	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	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	Up to a maximum of $25,000 for all home health care services from all providers.
	Rehabilitation services	20% coinsurance for occupational therapy 20% coinsurance for physical therapy 20% coinsurance for speech therapy	40% coinsurance for occupational therapy 40% coinsurance for physical therapy 40% coinsurance for speech therapy	None
		20% coinsurance for	40% coinsurance for	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	
	Habilitation services	occupational therapy 20% coinsurance for physical therapy 20% coinsurance for speech therapy	occupational therapy 40% coinsurance for physical therapy 40% coinsurance for speech therapy	
	Skilled nursing care	20% coinsurance	40% coinsurance	Up to a maximum of 120 days per calendar year for all inpatient facility services combined.
	Durable medical equipment	20% coinsurance	40% coinsurance	None
	Hospice services	20% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	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.)

- Cosmetic Surgery (except as specified in Plan benefits)
- Dental Care (except as specified in Plan benefits)
- Long-Term Care
- 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 (subject to coverage limitations)
- Bariatric Surgery
- Chiropractic Care
- Hearing Aids
- Infertility Treatment
- Non-emergency care when outside the U.S.
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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. You may also be able to continue coverage under the provisions of COBRA. For more information contact the CHS HR Service Center at 1-800-535-4640.

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 the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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.

Language Access Services:

Chinese (中文): 如果需要中文的帮助，请拨打这个号码	1-800-793-6932
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-800-793-6932
Spanish (Español): Para obtener asistencia en Español, llame al	1-800-793-6932
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-800-793-6932

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	$1,400
Specialist copayment	$0
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)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$2,025
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,485**

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

The plan's overall deductible	$1,400
Specialist copayment	$0
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)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$1,437
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$2,892**

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

The plan's overall deductible	$1,400
Specialist copayment	$0
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)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,400
Copayments	$0
Coinsurance	$385
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,785**

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.