

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
T25124 Aware® HSA \$6,500 Ded 0% Coins

Coverage period beginning on or after 1/1/2025
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 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 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?	\$6,500 individual / \$13,000 family in-network \$10,000 individual / \$20,000 family out-of-network	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 in this 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 .
Are there services covered before you meet your deductible?	Yes. Well child care, prenatal care, and in-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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	\$6,500 individual / \$13,000 family in-network \$15,000 individual / \$30,000 family out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services. This plan has an embedded out-of-pocket limit . 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.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count towards the out-of-pocket limit .
Will you pay less if you use an in-network provider?	Yes. Your network is Aware®. See bluecrossmn.com/find-doctor or call 1-866-873-5943 for a list of in-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 in-network provider might use an out-of-network provider for some

Important Questions	Answers	Why This Matters:
		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
		In-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	0% coinsurance	50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/immunization	No charge	Well child: No charge Adult: 50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	May require prior authorization.
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at bluecrossmn.com	Tier 1 drugs	0% coinsurance	Not covered	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 deductible first. The value of drug coupons you use may count towards cost sharing or out-of-pocket limits . Drugs and drug tiers on the formulary may change with notice. May require prior authorization.
	Tier 2 drugs	0% coinsurance	Not covered	
	Tier 3 drugs	0% coinsurance	Not covered	
	Tier 4 drugs	0% coinsurance	Not covered	
	Specialty drugs	0% coinsurance	Not covered	Covers up to a 31-day supply (participating specialty drug network supplier required). You will pay no more

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)	
				than \$25 for a one-month supply for each prescription for eligible drugs to treat certain chronic diseases. You may need to meet your deductible first. The value of drug coupons you use may count towards cost sharing or out-of-pocket limits . Drugs and drug tiers on the formulary may change with notice. May require prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	May require prior authorization.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services applies to in-network deductible and out-of-pocket limit .
	Emergency medical transportation	0% coinsurance	0% coinsurance	
	Urgent care	0% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	May require prior authorization.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance use services	Outpatient services	0% coinsurance	50% coinsurance	Services for marriage/couples counseling are not covered. May require prior authorization.
	Inpatient services, including residential adult mental health treatment	0% coinsurance	50% coinsurance	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: 0% coinsurance	Prenatal care: No charge Postnatal care: 50% coinsurance	Cost sharing does not apply for preventive services . Depending on the type of service or if maternity complications arise, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	
If you need help recovering or have	Home health care	0% coinsurance	Not covered	May require prior authorization.
	Rehabilitation services	0% coinsurance	50% coinsurance	Includes physical therapy, speech

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
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other special health needs	Habilitation services	0% coinsurance	50% coinsurance	therapy, and occupational therapy. May require prior authorization.
	Skilled nursing care	0% coinsurance	50% coinsurance	Combined 120 days per person per benefit period. May require prior authorization.
	Durable medical equipment	0% coinsurance	50% coinsurance	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 deductible first. May require prior authorization.
	Hospice services	0% coinsurance	Not covered	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: 50% coinsurance	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
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult) (and children)
- Drugs not on the covered drug list unless an exception is obtained
- Infertility treatment
- 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.)

- Chiropractic care
- 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; 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. 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.org 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 on how 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; 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. 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, kwijjigo 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](#), [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	\$6,500
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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 **\$12,700**

In this example, Peg would pay:

Cost Sharing

Deductibles	\$6,500
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions **\$60**

The total Peg would pay is **\$6,560**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$6,500
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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 **\$5,600**

In this example, Joe would pay:

Cost Sharing

Deductibles	\$2,300
Copayments	\$300
Coinsurance	\$0

What isn't covered

Limits or exclusions **\$20**

The total Joe would pay is **\$2,620**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$6,500
■ Specialist coinsurance	0%
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

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 **\$2,800**

In this example, Mia would pay:

Cost Sharing

Deductibles	\$2,800
Copayments	\$0
Coinsurance	\$0

What isn't covered

Limits or exclusions **\$0**

The total Mia would pay is **\$2,800**

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

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, 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
- 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.

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M09163 (8/24)

<p>ကည်ကို (Karen)</p> <p>ဟုသူ့ဟုသူ့- နမ့်ကတိ၊ ကည်ကို နှုံး၊ နယ့်ကိုဂုံးတ်တ်စာမာစာတလ်ဘူးလဲ သူနှုံးလို့၊ နမ့်အိုးတ်တလ်တပဲ့လာ မဲ့တ်တံ့ုံး၊ တ်နှုံး၊ မ့်တမ့် တ်စံးကတိတ်နှုံး ပလေးကျေးကျိုးတ်လာ၊ ကျော်တိုးတ်တိုးအဂ္ဂာကတ်လာနှိုးသူနှုံးလို့၊ တ်အံး၊ ပုံးတ်နှုံးတ်နှုံးအပျော်ကျိုးတ်တ်တံ့ုံး၊ တ်ဟုံးလုံးတ်တံ့ုံး၊ အလုံးဖျော်ဖူးအံး၊ မ့်တမ့် ပုံးတ်ဘုံးအလုံး၊ တ်ကလုံး၊ မ့်တမ့် တ်မာစာတရှုံးတ်တံ့ုံး၊ လာတလ်အားးလဲနှုံးလို့၊ ကိုလီတဲ့စဲ့ဆူ 1-855-903-2583 (TTY 711) တက်း</p>	<p>မြန်မာဘာသာ (Burmese)</p> <p>သတိပြုရန်- သင်သည် မြန်မာဘာသာ စကားကို ပြောပါက၊ အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများကို တောင်းဆိုင်ပါသည်။ သင့်တွင် အမြင်အာရုံး၊ အကြေားအာရုံး၊ သို့မဟုတ် စကားပြောခြင်း၊ ချို့ယွင်းမှုရှိနေပါက သင့်အတွက် အသင့်လျှော်ဆုံးဖြစ်မည်နည်းလမ်းဖြင့် ကွဲနှုပ်တို့ထဲသို့ ဆက်သွယ်နိုင်ပါသည်။ ငါးတွင် လက်ဟန်ပြောဘာသာစကား စကားပြန်များကို အသုံးပြုခြင်း၊ စာရွက်စာတမ်းများကို ပုံနှိပ်စာလုံးကြီးများ၊ သို့မဟုတ် မျက်မမြင်စာဖြင့် ပုံပြုပေးခြင်း၊ အသံမျှခြင်းများ သို့မဟုတ် အခြားအထောက်အကူများဖြင့် အခမဲ့ပံ့ပို့ပေးခြင်းတို့ ပါဝင်ပါသည်။ 1-855-903-2583 (TTY 711) သို့ ဖုန်းခေါ်ခို့ပါ။</p>
<p>OROMOO (Oromo)</p> <p>Xiyyeefannoona ha kennamu:- Oromo Afan kan dubbatan yoo ta'e, tajaajiloota gargaarsa afaanii bilisaa gaafachuu ni dandeessu. Rakkoo ilaaluu, dhaga'u ykn dubbachuu yoo qabaattan, karaa isiniif mijatuun haala isiniif galuun mari'achuu ni dandeenyaa. Kunis of keessatti kan qabatu, hiiktota afaan mallattoo fayyadamuun maxxansa gurguddaa ykn bireylii, waraabbiwwan sagalee ykn gargaarsota biroo kaffaltii tokkoo malee gaafachuu dha. 1-855-903-2583 (TTY 711) irratti bilbilaa.</p>	<p>РУССКИЙ (Russian)</p> <p>ВНИМАНИЕ: Если ваш язык — РУССКИЙ, вы можете запросить бесплатные услуги языковой поддержки. Если у вас есть нарушение зрения, слуха или речи, мы можем общаться таким образом, который лучше всего подходит вам. Это может включать бесплатное использование переводчиков на языке жестов, предоставление документов крупным шрифтом или шрифтом Брайля, использование аудиозаписей или других вспомогательных средств. Звоните по телефону 1-855-903-2583 (TTY 711).</p>
<p>ພາສາລາວ (Lao)</p> <p>ເອົາໃຈໃສ່: ຖ້າທ່ານເວົ້າ ພາສາລາວ, ທ່ານສາມາດຂໍບໍລິການອ່ວຍເຫຼືອດ້ານພາສາໄດ້ດີລົ່ມເສຍຄ່າ. ຖ້າທ່ານມີຄວາມບັກຜ່ອງດ້ານສາຍາຕາ, ການໄດ້ຍືນ ຫຼື ການປາກເວົ້າ, ພວກເຮົາສາມາດສ້າງດ້ວຍວິທີທີ່ເຫັນຈະສົມກັບທ່ານທີ່ສູດ. ຂັນນີ້ອາດຈະລວມຕົງການໃຊ້ນໍາຍພາສານີ້, ການລັດງານມອງກະສາງບັນໄຕເມີນໃຫຍ່ ຫຼື ຂັກສອນນຸ່ມ, ການບັນທຶກຮັງງານ ຫຼື ການອ່ວຍເຫຼືອດ້ານສ້ອງງົງໂດຍລົ່ມເສຍຄ່າໃຈຊ່າຍໃດໆ. ຂັບ 1-855-903-2583 (TTY 711).</p>	<p>Tagalog (Tagalog)</p> <p>PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang humingi ng mga libreng serbisyong tulong sa wika. Kung may kapansanan ka sa paningin, pandinig, o pananalita, maaari tayong mag-usap sa paraan na pinakamabuti para sa iyo. Maaaring kabilang dito ang paggamit ng mga interpreter ng sign language, pagbibigay ng mga dokumento na malalaki ang pagkaprinta o Braille, mga audio recording, o iba pang mga tulong nang walang bayad. Tumawag sa 1-855-903-2583 (TTY 711).</p>
<p>VIETNAMESE (Vietnamese)</p> <p>LUU' Ý: Nếu quý vị nói Vietnamese, quý vị có thể yêu cầu dịch vụ hỗ trợ ngôn ngữ miễn phí. Nếu quý vị bị khiếm thị, khiếm thính hoặc khuyết tật về âm ngữ, chúng tôi có thể giao tiếp theo cách phù hợp nhất với quý vị. Điều này có thể bao gồm việc sử dụng thông dịch viên ngôn ngữ ký hiệu, cung cấp tài liệu dạng bản in cỡ chữ lớn hoặc chữ nổi, bản ghi âm hoặc các phương tiện hỗ trợ khác miễn phí. Xin gọi số 1-855-903-2583 (TTY 711).</p>	<p>简体中文 (Chinese Simplified)</p> <p>注意: 如果您说普通话, 则可以免费申请语言协助服务。如果您有视力、听力或语言障碍, 我们可以用最适合您的方式与您交流。这可能包括免费提供手语翻译、大字体或盲文文件、录音或其他辅助工具。请致电 1-855-903-2583 (文字电话 711)。</p>

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M09164 (8/24)

