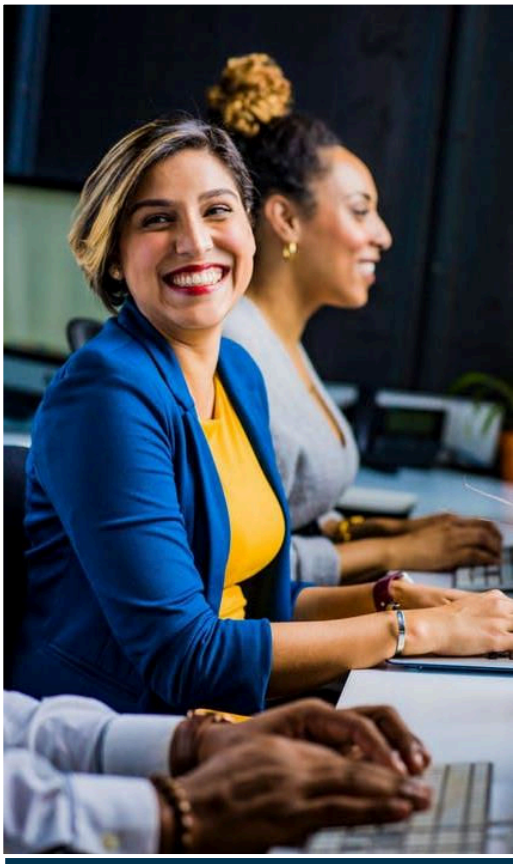
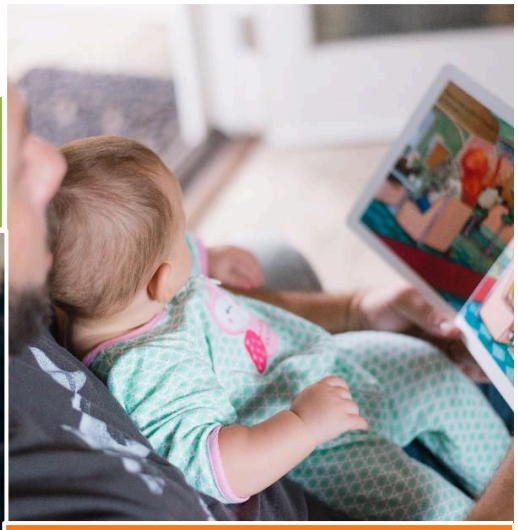
July 1, 2022

Benefits Enrollment Guide

Waconia Public Schools





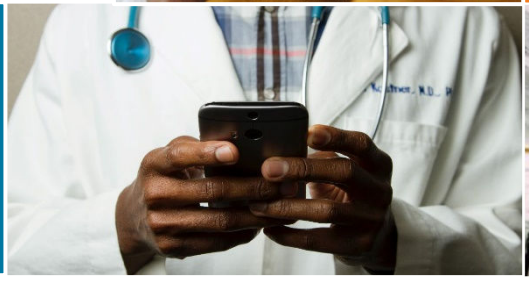
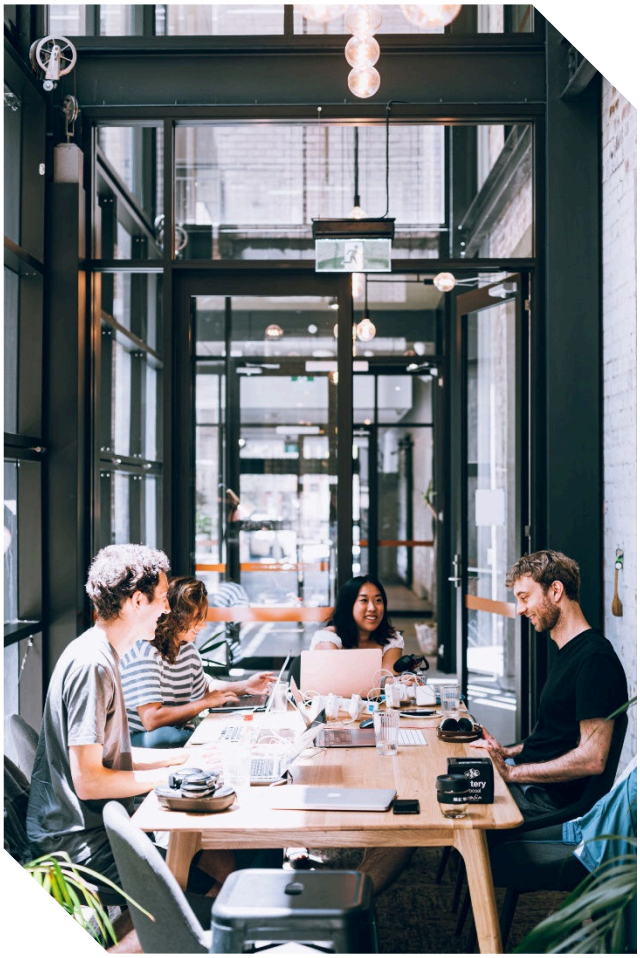


TABLE OF CONTENTS



The following descriptions of available benefit elections options, are purely informational and have been provided to you for illustrative purposes only. Payment of benefits will vary from claim to claim within a particular benefit option and will be paid at the sole discretion of the applicable insurance provider for each benefit option. The terms and conditions of each applicable policy or certificate of coverage will provide specific details and will govern in all matters relating to each particular benefit option described in this summary. In no case will any information in this summary amend, modify, expand, enhance, improve or otherwise change any term, condition or element of the policies or certificates of coverage that govern the benefit options described in this summary.

Presented by:

ONEDIGITAL HEALTH AND BENEFITS

ENROLLMENT AND ELIGIBILITY

Offering a comprehensive and competitive benefits package is one way we recognize your contribution to the success of the organization and our role in helping you and your family to be healthy, feel secure and maintain work/life balance. This enrollment guide has been designed to provide you with information about the benefit choices available to you. Remember, open enrollment is your only opportunity each year to make changes to your elections, unless you or your family members experience an eligible "change in status."

How to Enroll in the Plans

- To enroll in benefits, go to: **www.plansource.com/login**.
- Login using the username and password information that was emailed to your district email address.
- If you have any questions, or need any assistance, please contact:

  Christine Steffen

  Human Resources Coordinator Waconia Public Schools csteffen@isd110.org

  (952) 856-4513

Whom Can You Add to Your Plan?

Eligible:

- Legally married spouse
- Natural or adopted children up to age 26, regardless of student and marital status
- Children under your legal guardianship
- Stepchildren
- Children under a qualified medical child support order
- Disabled children 19 years or older
- Children placed in your physical custody for adoption

Ineligible:

- Divorced or legally separated spouse
- Common law spouse, even if recognized by your state
- Domestic partners, unless your employer states otherwise
- Foster children
- Sisters, brothers, parents or in-laws, grandchildren, etc.

Change in Status

Generally, you may enroll in the plan, or make changes to your benefits, when you are first eligible. However, you can make changes/enroll during the plan year if you experience a change in status. As with a new enrollee, you must submit your paperwork within 30 days of the change or you will be considered a late enrollee.

Examples of changes in status:

- You get married, divorced or legally separated
- You have a baby or adopt a child
- You or your spouse takes an unpaid leave of absence
- You or your spouse has a change in employment status
- Your spouse dies
- You become eligible for or lose Medicaid coverage
- Significant increase or decrease in plan benefits or cost

Did you know?

Open Enrollment is the only chance to make changes, unless you experience a "change in status."

PACKAGE OVERVIEW & CONTACT INFORMATION

Waconia Public Schools offers eligible employees a comprehensive benefit package that provides both financial stability and protection. Our offering provides flexibility for employees to design a package to meet their unique needs.

Effective July 1, 2022:

- Medical benefit plans with BlueCross BlueShield
- Dental benefit plan with Delta Dental
- Vision benefit plan with EyeMed
- Basic Life / AD&D plans with New York Life (formerly Cigna)
- Long term disability plans with New York Life (formerly Cigna)

After you have enrolled in insurance coverage, you will receive additional information in the mail from the insurance carriers. This information will contain your personal identification cards. In the meantime, you can look up providers for your plans on the internet.

BlueCross BlueShield: https://www.bluecrossmnonline.com/find-a-doctor/landing

Delta Dental: https://www.deltadentalmn.org/find-a-dentist/#/start

EyeMed: https://eyemed.com/

HR contact at Waconia Public Schools: Christine Steffen

MEDICAL PLAN - $0, Deductible $20 Co-Pay Plan (Page 1)

	In network* MN Network – Aware National Network – BlueCard PPO	Out of network**
Plan-year deductible The in- and out-of-network maximums accumulate separately. Deductible carryover applies.	Medical $0 single $0 family	Medical $200 single $600 family
Coinsurance	0%	Deductible then 25% coinsurance
Plan-year out-of-pocket maximum The in- and out-of-pocket maximums accumulate separately. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical $750 single $1,500 family Prescriptions: $300 per person; $500 per family	Medical $1,500 single $3,000 family Prescriptions: $300 per person; $500 per family
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care • well-child care to age 6 • prenatal care • preventive medical evaluations age 6 and older • cancer screening • preventive hearing and vision exams • immunizations and vaccinations	 0% 0% 0% 0% 0% 0%	 0% 0% Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance
Omada® diabetes and cardiovascular disease prevention program	0%	No coverage
Physician services • e-visits • in-hospital medical visits • surgery and anesthesia • professional lab services • office visits due to illness or injury • urgent care (clinic-based) • retail health clinic • professional diagnostic imaging • allergy injections and serum	 0% 0% 0% 0% 0% after $20 copay 0% after $20 copay 0% 0% 0%	 Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance
Other professional services • chiropractic manipulation • chiropractic therapy • home health care • physical therapy, occupational therapy, speech therapy	 0% after $20 copay 0% 0% 0% after $20 copay	 Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance
• **Inpatient hospital services**	Deductible then 0%	Deductible then 25% coinsurance
Outpatient hospital services • facility diagnostic imaging • facility lab services • chemotherapy and radiation therapy • physical, occupational and speech therapy • scheduled outpatient surgery • urgent care (hospital-based)	 0% 0% 0% 0% 0% 0%	 Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

MEDICAL PLAN - $0, Deductible $20 Co-Pay Plan (Page 2)

	In network* MN Network – Aware National Network – BlueCard PPO	Out of network**
Emergency care • emergency room • physician charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	0% after $40 copay 0% 0%	
• **Medical supplies**	0%	Deductible then 25% coinsurance
Behavioral health (mental health and chemical dependency care) • inpatient care • outpatient care • professional care	 0% 0% 0%	 Deductible then 25% coinsurance Deductible then 25% coinsurance Deductible then 25% coinsurance
Prescription drugs – Select Network • **retail** (34-day limit) • **FlexRx preferred drug list** • Open plan design • preferred generic • preferred brand • non-preferred	 $15 copay $25 copay $40 copay	 $15 copay $25 copay $40 copay
• **90dayRx – Mail order pharmacy** (90-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $30 copay $50 copay $80 copay	 No coverage No coverage No coverage
• **90dayRx – Retail pharmacy** (90-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $30 copay $50 copay $80 copay	 No coverage No coverage No coverage
	90dayRx applies to participating retail and/or mail service pharmacy only. Identified specialty drugs purchased through a specialty pharmacy network supplier are eligible for coverage (no coverage for specialty drugs purchased through a nonparticipating specialty pharmacy supplier). The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available. The drug list uses a step therapy program. Sign in at **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.com**.

***Lowest out-of-pocket costs**: in-network providers
****Higher out-of-pocket costs**: out-of-network participating providers
Highest out-of-pocket costs: out-of-network **nonparticipating** providers (You are responsible for the difference between Blue Cross' allowed amount and the amount billed by nonparticipating providers. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on Blue Cross' allowed amount, which is typically lower than the amount billed by the provider.)

This is only a summary. Read your benefit booklet for more information about what is and isn't covered. Services that aren't covered include those that are cosmetic, investigative, not medically necessary or covered by workers' compensation or no-fault insurance.

For more information, visit **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

Embedded deductible – The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.

MEDICAL PLAN - $500 Deductible Plan (Page 1)

	In network* MN Network – Aware National Network: BlueCard Traditional	Out of network**
Plan-year deductible The deductible for all networks cross apply. Deductible carryover applies	Medical $500 single $1,000 family	
Coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Plan-year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical $750 single $1,500 family Prescription: $300 per person; $500 per family	
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care • well-child care to age 6 • prenatal care • preventive medical evaluations age 6 and older • cancer screening • preventive hearing and vision exams • immunizations and vaccinations	 0% 0% 0% 0% 0% 0%	 0% 0% 0% 0% 0% 0%
Omada® • diabetes and cardiovascular disease prevention program	0%	No coverage
Physician services • e-visits • in-hospital medical visits • surgery and anesthesia • professional lab services • office visits due to illness or injury • urgent care (clinic-based) • retail health clinic • professional diagnostic imaging • allergy injections and serum	 First 5 e-visits 0%, subsequent visits Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance
Other professional services • chiropractic manipulation • chiropractic therapy • home health care • physical therapy, occupational therapy, speech therapy	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance
• **Inpatient hospital services**	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Outpatient hospital services • facility diagnostic imaging • facility lab services • chemotherapy and radiation therapy • physical, occupational and speech therapy • scheduled outpatient surgery • urgent care (hospital-based)	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	 Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance

MEDICAL PLAN - $500 Deductible Plan (Page 2)

	In network* MN Network – Aware National Network: BlueCard Traditional	Out of network**
Emergency care • emergency room • physician charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	
• **Medical supplies**	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Behavioral health (mental health and chemical dependency care) • inpatient care • outpatient care • professional care	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance
Prescription drugs –Select Network • **retail** (34-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $15 copay $25 copay $40 copay	 $15 copay $25 copay $40 copay
• **90dayRx – Mail order pharmacy** (90-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $30 copay $50 copay $80 copay	 No coverage No coverage No coverage
• **90dayRx – Retail pharmacy** (90-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $30 copay $50 copay $80 copay	 No coverage No coverage No coverage
	90dayRx applies to participating retail and/or mail service pharmacy only. Identified specialty drugs purchased through a specialty pharmacy network supplier are eligible for coverage (no coverage for specialty drugs purchased through a nonparticipating specialty pharmacy supplier). The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available. The drug list uses a step therapy program. Sign in at **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.com**.

***Lowest out-of-pocket costs**: in-network providers
****Higher out-of-pocket costs**: out-of-network participating providers
Highest out-of-pocket costs: out-of-network **nonparticipating** providers (You are responsible for the difference between Blue Cross' allowed amount and the amount billed by nonparticipating providers. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on Blue Cross' allowed amount, which is typically lower than the amount billed by the provider.)

This is only a summary. Read your benefit booklet for more information about what is and isn't covered. Services that aren't covered include those that are cosmetic, investigative, not medically necessary or covered by workers' compensation or no-fault insurance.

For more information, visit **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

Embedded deductible – The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.

MEDICAL PLAN - $1750 Deductible Plan with VEBA (Page 1)

Not Available to Teachers

	In network* MN Network – Aware National Network: BlueCard Traditional	Out of network**
Plan-year deductible The deductible for all networks cross apply. Deductible carryover applies	Medical $1,750 single $3,500 family	
Coinsurance	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Plan-year out-of-pocket maximum The in- and out-of-pocket maximums cross apply. Non-covered charges and charges in excess of the allowed amount do not apply to the out-of-pocket maximum.	Medical and prescription combined $3,000 single $6,000 family	
Benefit payment levels	Payment for participating network providers as described. Most payments are based on allowed amount.	If nonparticipating provider services are covered, you are responsible for the difference between the billed charges and allowed amount. Most payments are based on allowed amount.
Preventive care		
• well-child care to age 6	0%	0%
• prenatal care	0%	0%
• preventive medical evaluations age 6 and older	0%	0%
• cancer screening	0%	0%
• preventive hearing and vision exams	0%	0%
• immunizations and vaccinations	0%	0%
Omada®		
• diabetes and cardiovascular disease prevention program	0%	No coverage
Physician services		
• e-visits	First 5 e-visits 0%, subsequent visits deductible then 20%	Deductible then 20% coinsurance
• in-hospital medical visits	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• surgery and anesthesia	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• professional lab services	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• office visits due to illness or injury	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• urgent care (clinic-based)	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• retail health clinic	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• professional diagnostic imaging	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• allergy injections and serum	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Other professional services		
• chiropractic manipulation	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• chiropractic therapy	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• home health care	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• physical therapy, occupational therapy, speech therapy	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• **Inpatient hospital services**	Deductible then 20% coinsurance	Deductible then 20%coinsurance
Outpatient hospital services		
• facility diagnostic imaging	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• facility lab services	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• chemotherapy and radiation therapy	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• physical, occupational and speech therapy	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• scheduled outpatient surgery	Deductible then 20% coinsurance	Deductible then 20% coinsurance
• urgent care (hospital-based)	Deductible then 20% coinsurance	Deductible then 20% coinsurance

MEDICAL PLAN - $1750 Deductible Plan with VEBA (Page 2)

Not Available to Teachers

	In network* MN Network – Aware National Network: BlueCard Traditional	Out of network**
Emergency care • emergency room • physician charges • ambulance (medically necessary transport to the nearest facility equipped to treat the condition)	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	
• **Medical supplies**	Deductible then 20% coinsurance	Deductible then 20% coinsurance
Behavioral health (mental health and chemical dependency care) • inpatient care • outpatient care • professional care	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance	Deductible then 20% coinsurance Deductible then 20% coinsurance Deductible then 20% coinsurance
Prescription drugs –Select Network • **retail** (34-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $20 copay $35 copay $50 copay	 $20 copay $35 copay $50 copay
• **90dayRx – Mail order pharmacy** (90-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $40 copay $70 copay $100 copay	 No coverage No coverage No coverage
• **90dayRx – Retail pharmacy** (90-day limit) **FlexRx preferred drug list** • open plan design • preferred generic • preferred brand • non-preferred	 $40 copay $70 copay $100 copay	 No coverage No coverage No coverage
	90dayRx applies to participating retail and/or mail service pharmacy only. Identified specialty drugs purchased through a specialty pharmacy network supplier are eligible for coverage (no coverage for specialty drugs purchased through a nonparticipating specialty pharmacy supplier). The patient will pay the difference if a brand-name drug is dispensed when a generic drug is available. The drug list uses a step therapy program. Sign in at **bluecrossmnonline.com** and select "Prescriptions," then see "frequently asked questions."	

Your out-of-pocket costs depend on the network status of your provider. To check status, call Blue Cross customer service or visit **bluecrossmnonline.com**.

***Lowest out-of-pocket costs**: in-network providers
****Higher out-of-pocket costs**: out-of-network participating providers
Highest out-of-pocket costs: out-of-network **nonparticipating** providers (You are responsible for the difference between Blue Cross' allowed amount and the amount billed by nonparticipating providers. This is in addition to any applicable deductible, copay or coinsurance. Benefit payments are calculated on Blue Cross' allowed amount, which is typically lower than the amount billed by the provider.)

This is only a summary. Read your benefit booklet for more information about what is and isn't covered. Services that aren't covered include those that are cosmetic, investigative, not medically necessary or covered by workers' compensation or no-fault insurance.

For more information, visit **bluecrossmnonline.com** or call Blue Cross customer service at the number on the back of your member ID card.

The Omada program is from Omada Health, Inc., an independent company providing digital intensive behavioral counseling program.

Embedded deductible – The plan begins paying benefits that require cost sharing for the first family member who meets the individual deductible. The family deductible must then be met by one or more of the remaining family members and then the plan pays benefits for all covered family members.

HRA/VEBA Non-teacher members enrolled in the $1750 Deductible Plan

Health Reimbursement Arrangements (HRAs) are a great way to save money and budget for qualified medical expenses.

For any questions or concerns with your account, please contact OneBridge:
Phone: 1-888-865-1628 Customer services hours Monday-Friday 8:00 a.m. to 7:00 p.m. (CST)

Claims may be submitted:
Directly on the One Portal: https://portal.yourwaybenefits.com/
Using your OneBridge debit card
or by Mail to: OneBridge FSA, PO Box 80866, Seattle, WA 98108

WHAT ARE THE BENEFITS OF AN HRA/VEBA?
There are many benefits of using an HRA/VEBAs, including the following:

It saves you money. Your employer contributes to your HRA/VEBA account to help you with out of pocket expenses. Please refer to your cost sheet and employment work agreement / terms and conditions of employment for District contribution.

It rolls over. Funds rollover from year to year so you don't have to worry about forfeitures

It can be used for just about anything—HRA/VEBA accounts can be used to pay for out of pocket expenses for medical, dental and vison.

The IRS expanded the eligible expenses list due to COVID-19 HRA/VEBA can now be used to purchase over-the-counter medical products, including those needed in quarantine and social distancing, and feminine hygiene products, without a prescription from a physician. This change occurred on March 27, 2020 as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act that Congress passed.

FLEXIBLE SPENDING ACCOUNTS (FSA)

Who is Eligible and When

All Full-Time Employees working at least 20 hours each week. Please check with your HR representative for specific eligibility requirements.

Benefits You Receive

FSAs provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pretax basis. By anticipating your family's health care and dependent care costs for the next year, you can actually lower your taxable income.

Health Care Reimbursement FSA

This program lets employees pay for certain IRS-approved medical care expenses and prescriptions not covered by their insurance plan with pretax dollars. There are limits on salary reduction contributions to a health FSA offered under a cafeteria plan and is applicable to both grandfathered and non-grandfathered health FSAs. This limit will be indexed for cost-of-living adjustments. Some examples of eligible expenses include:

- Hearing services, including hearing aids and batteries
- Vision services, including contact lenses, contact lens solution, eye examinations and eyeglasses
- Dental services and orthodontia
- Chiropractic services
- Acupuncture
- Prescription contraceptives

Dependent Care FSA

The Dependent Care FSA lets employees use pretax dollars toward qualified dependent care such as caring for children under the age 13 or caring for elders. The annual maximum amount you may contribute to the Dependent Care FSA is $5,000 (or $2,500 if married and filing separately) per calendar year. Examples include:

- The cost of child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

ONEBRIDGE
for your benefit

Flexible Spending Accounts (FSA) allow you to **set aside tax-exempt money to pay for eligible, out-of-pocket healthcare or dependent daycare costs**. You determine the amount you wish to contribute to your FSA annually. This contribution is withdrawn from your paycheck each pay period in equal amounts, before taxes are taken out, **saving you up to $.30 on every dollar contributed**. It's a smart, easy way to pay for your eligible medical and dependent care expenses.

Health FSA

A Health FSA covers general purpose health expenses, allowing you to pay for eligible medical, dental, prescription, vision and/or hearing expenses not covered by insurance, which may include:

- Copays, Premiums & Deductibles
- Prescriptions & Over-the-Counter (OTC) Items
- Non-Cosmetic Dental Treatments
- Glasses & Contacts
- Hearing Aids
- Orthodontia
- Physical Therapy
- Chiropractic Care

Save Smarter

There are several reasons why enrolling in an FSA makes sense. Perhaps one of the most important reasons is the money you save. An FSA helps **reduce your taxes and increase your take-home pay** due to the fact that you don't pay federal, state income or social security taxes on money placed into your FSA. Take a look at how the numbers could work:

Consider Your Future FSA Savings

See how much you stand to save on qualified healthcare expenses through a OneBridge FSA at onebridgebenefits.com/savings-calculator.

Annual Savings Chart

Your Annual Salary	$40,000	$80,000
Health FSA Election	$1,500	$2,500
Dependent Care FSA Election	$0	$5,000
Your Annual Savings[1]	$450	$2,250

Remember, be conservative in your estimates because money left in the account at the end of the year may be forfeited unless your employer allows FSA rollover or a grace period.

ONEBRIDGE
for your benefit

Flexible Spending Account Plan Details

Administrator	OneBridge Phone Number: 888-865-1628
Plan Year	July 01 – June 30
Employee Eligibility	Must be working 20 hours per week or more
Waiting Period for Enrollment (Time employee must wait before being eligible to enroll)	Date of hire
Initial Enrollment Period (Time frame after the waiting period during which employee must enroll)	30 days
Coverage Termination Date upon loss of Eligibility	Date of termination
Maximum Annual Health FSA Election	$2,850
Maximum Annual Dependent Care FSA Election	$ 5,000 ($2,500 if married but filing separately)
Pre-Tax Premiums Account (For health care and dental insurance premiums)	Premiums for Employer sponsored insurance plan are automatically withdrawn from your paycheck on a pre-tax basis.
Flex Run-Out Period (This is the number of days after the end of the plan year you have to file a claim that was incurred within the plan year)	90 days
Dependent Care Claims Grace Period (this is the time period after the end of the plan year during which you may incur dependent care claims. Claims incurred during this time period must be submitted for reimbursement before the end of the Flex Run-Out Period)	2 ½ months after the end of the plan year
Percent of Unused Health FSA or Limited Scope FSA Balance that rolls over into the next plan year	100% of prior year remaining balance not to exceed $550

DENTAL PLAN

Plan Benefit Highlights			
Network(s)	**Delta Dental PPO℠**	**Delta Dental Premier®**	**Non-Participating***
Plan Year Plan Maximum **(July 1 – June 30)** Per person	$1,000	$1,000	$1,000
Lifetime Ortho Maximum Per eligible covered person	$1,000	$1,000	$1,000
Deductible Per person per plan year *No deductible for diagnostic and preventive services or orthodontics*	$25/person	$25/person	$25/person
Eligible Dependents	Spouse Dependent children up to age 26		
Covered Services	**Dental Benefit Plan Coverage**		
Diagnostic & Preventive Services Exams Cleanings X-rays Fluoride treatments Space Maintainers	100%	100%	100%
Basic Services Emergency treatment for relief of pain Sealants Amalgam restorations (silver fillings) Composite resin restorations (white fillings) on anterior (front) teeth	80%	80%	80%
Endodontics Root canal therapy on permanent teeth Pulpotomies on primary teeth for dependent children	80%	80%	80%
Periodontics Surgical/Nonsurgical periodontics	80%	80%	80%
Oral Surgery Surgical/Nonsurgical extractions All other covered oral surgery	80%	80%	80%
Major Restorative Crowns Composite resin restorations (white fillings) on posterior (back) teeth	80%	80%	80%
Prosthetic Repairs and Adjustments Denture adjustments and repairs Bridge repair	80%	80%	80%
Prosthetics Dentures (full and partial) Bridges Limited Implant Coverage	80%	80%	80%
Orthodontics Treatment for the prevention/ correction of malocclusion	50%	50%	50%

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

VISION PLAN

SUMMARY OF BENEFITS

VISION CARE SERVICES	IN-NETWORK MEMBER COST	OUT-OF-NETWORK MEMBER REIMBURSEMENT
FRAME		
Frame	$0 copay; 20% off balance over $150 allowance	Up to $105
STANDARD PLASTIC LENSES		
Single Vision	$20 copay	Up to $30
Bifocal	$20 copay	Up to $50
Trifocal	$20 copay	Up to $70
Lenticular	$20 copay	Up to $70
Progressive - Standard	$85 copay	Up to $50
Progressive - Premium Tier 1 - 3	$105 - 130 copay	Up to $50
Progressive - Premium Tier 4	$85 copay; 20% off retail price less $120 allowance	Up to $50
LENS OPTIONS		
Anti Reflective Coating - Standard	$45	Not covered
Anti Reflective Coating - Premium Tier 1 - 2	$57 - 68	Not covered
Anti Reflective Coating - Premium Tier 3	20% off retail price	Not covered
Photochromic - Non-Glass	$75	Not covered
Polycarbonate - Standard	$40	Not covered
Scratch Coating - Standard Plastic	$15	Not covered
Tint - Solid and Gradient	$15	Not covered
UV Treatment	$15	Not covered
All Other Lens Options	20% off retail price	Not covered
CONTACT LENSES		
Contacts - Conventional	$0 copay; 15% off balance over $150 allowance	Up to $150
Contacts - Disposable	$0 copay; 100% of balance over $150 allowance	Up to $150
Contacts - Medically Necessary	$0 copay; paid in full	Up to $210
OTHER		
Hearing Care from Amplifon Network	Up to 64% off hearing aids; call 1.877.203.0675	Not covered
LASIK or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1.800.988.4221	Not covered

FREQUENCY	ALLOWED FREQUENCY - ADULTS	ALLOWED FREQUENCY - KIDS
Frame	Once every 24 months from the date of service	Once every 24 months from the date of service
Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service
Contact Lenses	Once every 12 months from the date of service	Once every 12 months from the date of service

(Plan allows member to receive either contacts and frame, or frames and lens services)

Monthly Rate

Subscriber	$6.22
Subscriber + Spouse	$11.81
Subscriber + Child(ren)	$12.44
Subscriber + Family	$18.28

BASIC LIFE & DISABILITY INSURANCE

Basic Life

Waconia Public Schools provides basic life coverage for benefit eligible employees. Refer to Employee Work Agreements for benefit coverage amounts.

Long Term Disability

Carrier Name	Cigna
Benefit	66.67% of Monthly Covered Earnings
Maximum Monthly Benefit	Refer to Employee Work Agreements
Minimum Monthly Benefit	$100 per Month
Elimination Period	90 Days
Duration of Benefits	Later of Employees Social Security Normal Retirement Age or Schedule Listed in Policies
Pre-Existing Limitation	3 / 12
Definition of Disability	**First 24 Months**: Unable to perform the material duties of occupation, or unable to earn 80% of indexed covered earnings **After 24 Months**: Unable to perform the material duties of any occupation based on education, training or experience, or unable to earn 80% of indexed covered earnings

Did you know?

41% of people with arthritis are forced to limit their physical activity, making it the leading cause of disability in the US.

- Illinois Department of Public Health. "Arthritis and Disability." 2007. Web Accessed November 10, 2014.

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

VOLUNTARY LIFE AND AD&D INSURANCE PLAN

Carrier Name	Cigna
Employee Life and AD&D Benefit	Increments of $10,000 to a Max of $500,000 ($100,000 Guaranteed Issue Amount for New Hires Only)
Dependent Life and AD&D Benefit **Spouse benefit Terms at Age 70**	**Spouse Life** : Increments of $5,000 to a Max of $250,000 Not to Exceed 50% of Employee Amount ($50,000 Guaranteed Issue Amount for New Hires Only) **Spouse AD&D Up to Age 70**: 60% of Employee Amount if no Children Insured and 50% if Children Insured to a Max of $250,000 **Child Life**: Increments of $1,000 to a Max of $10,000; $500 for Children Less than 6 Months Old **Child AD&D**: 15% of Employee Amount if no Spouse Insured and 10% if Spouse Insured to a Max of $10,000
Conversion Privilege	Conversion is Included
Waiver of Premium	To Age 70 with 6 Months Waiting Period

The benefit plan information shown in this guide is illustrative only. To the extent the benefit plan information summarized herein differs from the underlying plan details specified in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the underlying insurance documents will govern in all cases.

VOLUNTARY LIFE AND AD&D RATES

Coverage Tier	Full Monthly Rate
Voluntary Life	**Employee & Spouse* Rate per $1,000**
<20	$0.044
20-24	$0.069
25-29	$0.069
30-34	$0.069
35-39	$0.085
40-44	$0.122
45-49	$0.183
50-54	$0.291
55-59	$0.469
60-64	$0.719
65-69	$1.218
70-74	$2.311
75-79	$4.365
80-84	$8.672
85-89	$15.987
90-94	$26.084
95-99	$39.595
Child Voluntary Life per $1,000	$0.200
Employee Voluntary AD&D per $1,000	$0.025
Family Rate Voluntary AD&D per $1,000	$0.040

***Spouse coverage ends at age 70**
Please refer to the Term Life and Accident Insurance document for plan design details.

The rates shown in this guide are illustrative only. To the extent the rates contained herein differ from those in the insurance documents that govern the terms and conditions of the plans of insurance described in this guide, the rates in the underlying insurance documents will govern in all cases.

REQUIRED NOTICES

Newborn and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also cover reconstructive surgery and prostheses following mastectomies.

The law mandates that a member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will receive coverage for:

- reconstruction of the breast on which mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in a manner determined in consultation with the attending physician and the patient, and it will be subject to the same annual deductibles and coinsurance provisions as those established for other benefits under the plan. Please call your medical plan using the number on your identification card or contact the employer for more information.

Health Insurance Marketplace Options and Your Health Coverage

The Health Insurance Marketplace is designed to help individuals find, compare, and purchase private individual health insurance. The Marketplace does not affect your eligibility for coverage in your employer's group health plan.

Individuals may be eligible for a tax credit that lowers the monthly premium of coverage purchased in the Marketplace. However, if you are eligible for an employer's group health plan, you may not be eligible for a tax credit through the Marketplace if the employer group health plan meets the "minimum value" and "affordability" standards set by the Affordable Care Act. Additionally, if you purchase your own health plan through the Marketplace instead of accepting health coverage offered by your employer, then you will lose the employer contribution towards coverage. This employer contribution - as well as your employee contribution towards coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage you purchase through the Marketplace are made on an after-tax basis.

Open enrollment for individual health insurance coverage through the Marketplace occurs at the end of each calendar year for coverage effective the following January 1st. If you are interested, please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

REQUIRED NOTICES

Availability of HIPAA Privacy Notices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires health plans to protect the confidentiality of your personal health information ("PHI"). HIPAA also requires that health plans maintain privacy notices which provide a complete description of your rights under HIPAA's privacy rules. For insured coverage, the health insurance plan privacy notices are maintained by the insurance providers. For self-insured coverage, the privacy notice is maintained by your employer. In general, the plans will not use or further disclose PHI except as necessary for treatment, payment, health plan operations and plan administration or as permitted or required by law. Under HIPAA, you have certain rights with respect to your protected health information and the right to file a complaint with the plan or the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA has been violated. Please see the employer for a copy of the Notice of Privacy Practices for your health plans.

Notice of Special Enrollment Rights

If you decline enrollment for yourself or an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in the plans offered by the company if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). You must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. You must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

You may also be able to enroll if you or your dependents lose eligibility for coverage under Medicaid or a state Children's Health Insurance Plan (CHIP) and request enrollment within 60 days of losing Medicaid or CHIP. You may also be able to enroll if you or your dependents become eligible for state premium assistance from Medicaid or CHIP towards the cost of the group health plan, and request enrollment within 60 days of eligibility for state premium assistance.

Important Notice About Medicare Prescription Drug (Part D) Coverage

If you or one of your dependents is eligible for Medicare (or will be shortly), you may be able to purchase a Medicare prescription drug (Part D) plan or join a Medicare Advantage Plan that includes Part D coverage.

However, if you are enrolled in an employer group medical plan that includes "creditable" prescription drug coverage, you do not need a Medicare Part D plan, and you can enroll in a Medicare Part D plan later without paying a premium penalty. "Creditable" coverage means that the expected amount of paid claims under our prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare Part D plan. Creditable coverage can look different between plans, and the insurance carrier makes that determination through its own actuarial analysis.

All the employer group medical plans offered to our employees include prescription drug coverage. However, some of the plans may not provide "creditable" drug coverage. If you or one of your dependents is eligible for Medicare (or will be shortly), please verify that the plan you enroll in has "creditable" coverage prior to your enrollment in plan so that you don't incur a late enrollment penalty later. We also issue a Notice of Creditable or Non-Creditable Coverage each year to plan participants. For a copy of the Notice of Creditable or Non-Creditable Coverage or for more information, please contact the employer. You may also refer to www.medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

REQUIRED NOTICES

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed on the DOL website (**https://www.dol.gov/sites/default/files/ebsa/laws-and-regulations/laws/chipra/model-notice.pdf**), contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **https://www.insurekidsnow.gov/** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

CONFIDENTIALITY NOTICE

Digital Insurance LLC dba OneDigital Health and Benefits does not sell or share any information we learn about our clients and understands you may have to answer sensitive questions about your medical history, physical condition and personal health habits as required by our insurance carrier partners.

We collect nonpublic personal information from the following sources:

- Information from you, including data provided on applications or other forms, such as name, address, telephone number, date of birth and Social Security number
- Information from your transactions with us and/or our partners such as policy coverage, premium, claim, and payment history.

OneDigital Health and Benefits recognizes the importance of safeguarding the privacy of our clients and prospective clients, and we pledge to protect the confidential nature of your personal information. We understand our ability to provide access to affordable health insurance to businesses and individuals can only succeed with an environment of complete trust.

In the course of business, we may disclose all or part of your customer information without your permission to the following persons or entities for the following reasons:

- To an insurance carrier, agent or credit reporting agency to detect, prevent or prosecute actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a medical care institution or medical professional to verify coverage or benefits, to inform you of a medical problem of which you may or may not be aware or to conduct an audit that would enable us to verify treatment.
- To an insurance regulatory authority, law enforcement or other governmental authority to protect our interests in detecting, preventing or prosecuting actual or potential criminal activity, fraud, misrepresentation, unauthorized transactions, claims or other liabilities in connection with an insurance transaction.
- To a third party, for any other disclosures required or permitted by law. We may disclose all of the information that we collect about you, as described above.

Our practices regarding information confidentiality and security: We restrict access to your customer information only to those individuals who need it to provide you with products or services, or to otherwise service your account. In addition, we have security measures in place to protect against the loss, misuse and/or unauthorized alternation of the customer information under our control, including physical, electronic and procedural safeguards that meet or exceed applicable federal and state standards.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan or health insurance policy. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Underlined text indicates a term defined in this Glossary.
- See page 6 for an example showing how deductibles, coinsurance and out-of-pocket limits work together in a real life situation.

- **Allowed Amount**

This is the maximum payment the plan will pay for a covered health care service. May also be called "eligible expense", "payment allowance", or "negotiated rate".

- **Appeal**

A request that your health insurer or plan review a decision that denies a benefit or payment (either in whole or in part).

- **Balance Billing**

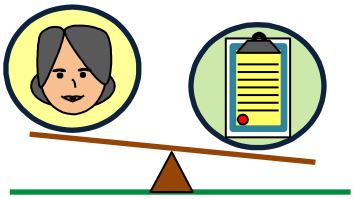
When a provider bills you for the balance remaining on the bill that your plan doesn't cover. This amount is the difference between the actual billed amount and the allowed amount. For example, if the provider's charge is $200 and the allowed amount is $110, the provider may bill you for the remaining $90. This happens most often when you see an out-of-network provider (non-preferred provider). A network provider (preferred provider) may not bill you for covered services.

- **Claim**

A request for a benefit (including reimbursement of a health care expense) made by you or your health care provider to your health insurer or plan for items or services you think are covered.

- **Coinsurance**

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. You generally pay coinsurance plus any deductibles you owe. (For example, if the health insurance or plan's allowed amount for an office visit is$100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

- **Complications of Pregnancy**

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non- emergency caesarean section generally aren't complications of pregnancy.

- **Copayment**

A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

- **Cost Sharing**

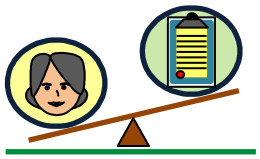
Your share of costs for services that a plan covers that you must pay out of your own pocket (sometimes called "out-of-pocket costs"). Some examples of cost sharing are copayments, deductibles, and coinsurance. Family cost sharing is the share of cost for deductibles and out- of-pocket costs you and your spouse and/or child(ren)must pay out of your own pocket. Other costs, including your premiums, penalties you may have to pay, or the cost of care a plan doesn't cover usually aren't considered cost sharing.

- **Cost-sharing Reductions**

Discounts that reduce the amount you pay for certain services covered by an individual plan you buy through the Marketplace. You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally- recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

- **Deductible**

An amount you could owe during a coverage period (usually one year) for covered health care services before your plan begins to pay. An overall deductible applies to all or almost all covered items and services. A plan with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A plan may also have only separate deductibles. (For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% | Her plan pays 0%

(See page 6 for a detailed example.)

- **Diagnostic Test**

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

- **Durable Medical Equipment (DME)**

Equipment and supplies ordered by a health care provider for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

- **Emergency Medical Condition**

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

- **Emergency Medical Transportation**

Ambulance services for an emergency medical condition. Types of emergency medical transportation may include transportation by air, land, or sea. Your plan may not cover all types of emergency medical transportation, or may pay less for certain types.

- **Emergency Room Care / Emergency Services**

Services to check for an emergency medical condition and treat you to keep an emergency medical condition from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for emergency medical conditions.

- **Excluded Services**

Health care services that your plan doesn't pay for or cover.

- **Formulary**

A list of drugs your plan covers. A formulary may include how much your share of the cost is for each drug. Your plan may put drugs in different cost sharing levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different cost sharing amounts will apply to each tier.

- **Grievance**

A complaint that you communicate to your health insure or plan.

- **Habilitation Services**

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/ or outpatient settings.

- **Health Insurance**

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a premium. A health insurance contract may also be called a "policy" or "plan".

- **Home Health Care**

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care providers. Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

- **Hospice Services**

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

- **Hospitalization**

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some plans may consider an overnight stay for observation as outpatient care instead of inpatient care.

- **Hospital Outpatient Care**

Care in a hospital that usually doesn't require an overnight stay.

- **Individual Responsibility Requirement**

Sometimes called the "individual mandate", the duty you may have to be enrolled in health coverage that provides minimum essential coverage. If you don't have minimum essential coverage, you may have to pay a penalty when you file your federal income tax return unless you qualify for a health coverage exemption.

- **In-network Coinsurance**

Your share (for example, 20%) of the allowed amount for covered healthcare services. Your share is usually lower for in-network covered services.

- **In-network Copayment**

A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

- **Marketplace**

A marketplace for health insurance where individuals, families and small businesses can learn about their plan options; compare plans based on costs, benefits and other important features; apply for and receive financial help with premiums and cost sharing based on income; and choose a plan and enroll in coverage. Also known as an "Exchange". The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children's Health Insurance Program (CHIP). Available online, by phone, and in-person.

- **Maximum Out-of-pocket Limit**

Yearly amount the federal government sets as the most each individual or family can be required to pay in cost sharing during the plan year for covered, in-network services. Applies to most types of health plans and insurance. This amount may be higher than the out-of- pocket limits stated for your plan.

- **Medically Necessary**

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

- **Minimum Essential Coverage**

Health coverage that will meet the individual responsibility requirement. 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.

- **Minimum Value Standard**

A basic standard to measure the percent of permitted costs the plan covers. If you're offered an employer plan that pays for at least 60% of the total allowed costs of benefits, the plan offers minimum value and you may not qualify for premium tax credits and cost sharing reductions to buy a plan from the Marketplace.

- **Network**

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

- **Network Provider (Preferred Provider)**

A provider who has a contract with your health insurer or plan who has agreed to provide services to members of a plan. You will pay less if you see a provider network. Also called "preferred provider" or in the "participating provider."

- **Orthotics and Prosthetics**

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.

- **Out-of-network Coinsurance**

Your share (for example, 40%) of the allowed amount for covered health care services to providers who don't contract with your health insurance or plan. Out-of- network coinsurance usually costs you more than in- network coinsurance.

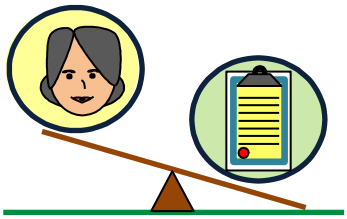
- **Out-of-network Copayment**

A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

- **Out-of-network Provider (Non-Preferred Provider)**

A provider who doesn't have a contract with your plan to provide services. If your plan covers out-of-network services, you'll usually pay more to see an out-of-network provider than a preferred provider. Your policy will explain what those costs may be. May also be called "non-preferred" or "non-participating" instead of "out-of-network provider".

- **Out-of-pocket Limit**



(See page 6 for a detailed example.)

The most you could pay during a coverage period (usually one year) for your share of the costs of covered services. After you meet this limit the plan will usually pay 100% of the allowed amount. This limit helps you plan for health care costs. This limit never includes your premium, balance-billed charges or health care your plan doesn't cover. Some plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments, or other expenses toward this limit.

- **Physician Services**

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

- **Plan**

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called "health insurance plan", "policy", "health insurance policy" or "health insurance".

- **Preauthorization**

A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment (DME) is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

- **Premium**

The amount that must be paid for your health insurance or plan. You and/ or your employer usually pay it monthly, quarterly, or yearly.

- **Premium Tax Credits**

Financial help that lowers your taxes to help you and your family pay for private health insurance. You can get this help if you get health insurance through the Marketplace and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly premium costs.

- **Prescription Drug Coverage**

Coverage under a plan that helps pay for prescription drugs. If the plan's formulary uses "tiers" (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in cost sharing will be different for each "tier" of covered prescription drugs.

- **Prescription Drugs**

Drugs and medications that by law require a prescription.

- **Preventive Care (Preventive Service)**

Routine health care, including screenings, check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

- **Primary Care Physician**

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

- **Primary Care Provider**

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the plan, who provides, coordinates, or helps you access a range of health care services.

- **Provider**

Some examples of a provider include a doctor, An individual or facility that provides health care services. chiropractor, physician assistant, hospital, surgical center, nurse, skilled nursing facility, and rehabilitation center. plan may require the provider to be licensed, certified, or the accredited as required by state law.

- **Reconstructive Surgery**

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

- **Referral**

A written order from your primary care provider for you to see a specialist or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for the services.

- **Rehabilitation Services**

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and or outpatient settings.

- **Screening**

A type of preventive care that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

- **Skilled Nursing Care**

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is not the same as "skilled care services", which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

- **Specialist**

A provider focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

- **Specialty Drug**

A type of prescription drug that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a formulary.

- **UCR (Usual, Customary and Reasonable)**

The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

- **Urgent Care**

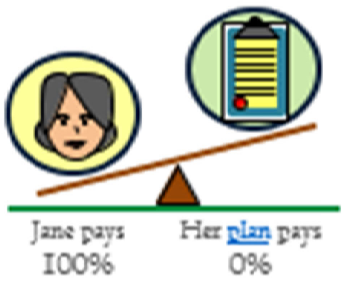
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

How You and Your Insurer Share Costs - Example

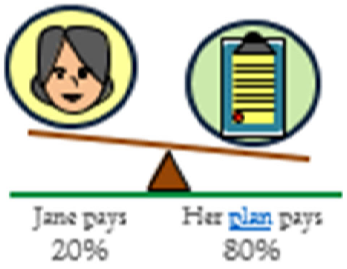
Jane's Plan Deductible: $1,500 **Coinsurance:** 20% **Out-of-Pocket Limit:** $5,000

January 1st
Beginning of Coverage Period

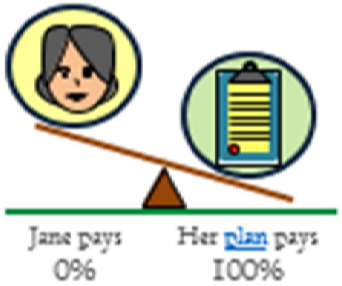
December 31st
End of Coverage Period



more costs



more costs



Jane hasn't reached her $1,500 deductible yet

Her plan doesn't pay any of the costs.

Office visit costs: $125
Jane pays: $125
Her plan pays: $0

Jane reaches her $1,500 deductible, coinsurance begins

Jane has seen a doctor several times and paid $1,500 in total, reaching her deductible. So her plan pays some of the costs for her next visit.

Office visit costs: $125
Jane pays: 20% of $125 = $25
Her plan pays: 80% of $125 = $100

Jane reaches her $5,000 out-of-pocket limit

Jane has seen the doctor often and paid $5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.

Office visit costs: $125
Jane pays: $0
Her plan pays: $125

CARRIERS, VENDORS & CONTACTS

Program	Vendor	Contact Information
Medical/Rx	BlueCross BlueShield	Member Service 866-873-5943
Dental	Delta Dental	Customer Service 1-800-448-3815 651-406-5901
Vision	EyeMed	Customer Service 866-800-5457
Basic Life/AD&D	New York Life Formerly Cigna	Client Guide Team 800-557-7975 ClientGuide@Cigna.com
Long Term Disability	New York Life Formerly Cigna	Client Guide Team 800-557-7975 ClientGuide@Cigna.com
EAP	Sand Creek EAP	1-888-243-5744
HRA/VEBA & FSA	OneBridge	1-888-865-1628

Waconia Public Schools

Additional Benefit Information

ONEDIGITAL
HEALTH AND BENEFITS

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
WACONIA INDEPENDENT SCHOOL DISTRICT NO 110

Coverage Period: Beginning on or after 07/01/2022
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 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	Answers	Why this Matters:
What is the overall deductible?	**$0** individual / **$0** family medical in-network **$200** individual / **$600** family medical out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
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?	**$750** individual / **$1,500** family medical in-network **$1,500** individual / **$3,000** family medical out-of-network **$300** individual / **$500** family drug combined in-network and 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, 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	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

	cover.	
Will you pay less if you use an in-network provider?	Yes. Your network is Aware. See https://www.bluecrossmnonline.com/find-a-doctor/#/home 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 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	$20 copay/office visit; no charge for all other services	25% coinsurance	None
	Specialist visit	$20 copay/office visit, no charge for all other services	25% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 25% 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)	No charge	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	No charge	25% coinsurance	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.bluecrossmnonline.com	Preferred generic drugs	$15.00 copay/prescription (retail) $30.00 copay/prescription (mail service) $30.00 copay/prescription (90dayRx retail)	$15.00 copay/prescription (retail)	Covers up to a 34-day supply, or 100 units, whichever is greater (retail prescription). 90-day supply (mail order prescription and 90dayRx retail prescription).

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)	
	Preferred brand drugs	$25.00 copay/prescription (retail) $50.00 copay/prescription (mail service) $50.00 copay/prescription (90dayRx retail)	$25.00 copay/prescription (retail)	No coverage for mail order and 90dayRx retail services from out-of-network providers. Insulin listed on the preferred generic/preferred brand prescription drug list are covered at zero cost-sharing.
	Non-preferred drugs	Non-preferred generic drugs: $40.00 copay/prescription (retail) $80.00 copay/prescription (mail service) $80.00 copay/prescription (90dayRx retail) Non-preferred brand drugs: $40.00 copay/prescription (retail) $80.00 copay/prescription (mail service) $80.00 copay/prescription (90dayRx retail)	Non-preferred generic drugs: $40.00 copay/prescription (retail) Non-preferred brand drugs: $40.00 copay/prescription (retail)	
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	Covers up to a 34-day supply (participating specialty drug network supplier prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge for outpatient hospital facility & ambulatory surgery center	25% coinsurance	None
	Physician/surgeon fees	No charge for outpatient hospital facility & ambulatory surgery center	25% coinsurance	None
If you need immediate medical attention	Emergency room care	$40 copay/visit	$40 copay/visit	Out-of-network services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	No charge	No charge	
	Urgent care	$20 copay/office visit; no charge for all other services	25% coinsurance	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)	No charge	25% coinsurance	None
	Physician/surgeon fee	No charge	25% coinsurance	None
If you need mental health, behavioral health, or substance use services	Outpatient services	No charge	25% coinsurance	None
	Inpatient services including residential adult mental health treatment	No charge	25% coinsurance	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: $20 copay/office visit; no charge for all other services	Prenatal care: No charge Postnatal care: 25% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	25% coinsurance	
	Childbirth/delivery facility services	No charge	25% coinsurance	
If you need help recovering or have other special health needs	Home health care	No charge	25% coinsurance	None
	Rehabilitation services	No charge for occupational therapy, physical therapy, and speech therapy	25% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Habilitation services	No charge for occupational therapy, physical therapy, and speech therapy	25% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	No charge	25% coinsurance	None
	Durable medical equipment	No charge	25% coinsurance	None
	Hospice service	No charge	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: 25% 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
- Hearing aids (Adult)
- Routine foot care

• Cosmetic surgery • Dental care (Adult) (and children)	• Long-term care • Non-emergency care when traveling outside the U.S.	• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric surgery • Chiropractic care	• Infertility treatment • Private-duty nursing	• 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 x 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, 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 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, kwiijigo holne' 1-855-902-2583.

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 prenatal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copay	**$20**
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	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$70**

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

The plan's overall deductible	**$0**
Specialist copay	**$20**
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	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$320**

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

The plan's overall deductible	**$0**
Specialist copay	**$20**
Hospital (facility) coinsurance	**0%**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$100**

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

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)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

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

နမ့်ကတိၤကညီကျိာ်ဒီး. တ၀်ကဟ့ဉ်နၤကျိာ်တ၀်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTYအဂိၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
WACONIA INDEPENDENT SCHOOL DISTRICT NO 110

Coverage Period: Beginning on or after 07/01/2022
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 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	Answers	Why this Matters:
What is the overall deductible?	**$500** individual / **$1,000** family medical combined in-network and out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
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?	**$750** individual / **$1,500** family medical combined in-network and out-of-network **$300** individual / **$500** family drug combined in-network and 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, 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 toward the out-of-pocket limit.

Will you pay less if you use an in-network provider?	Yes. Your network is Aware. See https://www.bluecrossmnonline.com/find-a-doctor/#/home 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 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	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 0% coinsurance; deductible does not apply	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)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.bluecrossmnonline.com	Preferred generic drugs	$15.00 copay/prescription (retail) $30.00 copay/prescription (mail service) $30.00 copay/prescription (90dayRx retail)	$15.00 copay/prescription (retail)	Covers up to a 34-day supply, or 100 units, whichever is greater (retail prescription). 90-day supply (mail order prescription and 90dayRx retail prescription). No coverage for mail order and 90dayRx retail services from out-of-network providers. Insulin listed on the preferred generic/preferred brand prescription drug list are covered at zero cost-sharing.
	Preferred brand drugs	$25.00 copay/prescription (retail) $50.00 copay/prescription (mail service) $50.00 copay/prescription (90dayRx retail)	$25.00 copay/prescription (retail)	
	Non-preferred drugs	Non-preferred generic drugs:	Non-preferred generic drugs:	

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)	
		$40.00 copay/prescription (retail) $80.00 copay/prescription (mail service) $80.00 copay/prescription (90dayRx retail) Non-preferred brand drugs: $40.00 copay/prescription (retail) $80.00 copay/prescription (mail service) $80.00 copay/prescription (90dayRx retail)	$40.00 copay/prescription (retail) Non-preferred brand drugs: $40.00 copay/prescription (retail)	
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	Covers up to a 34-day supply (participating specialty drug network supplier prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for outpatient hospital facility & ambulatory surgery center	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance for outpatient hospital facility & ambulatory surgery center	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fee	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance use services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services including residential adult mental health treatment	20% coinsurance	20% coinsurance	

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 are pregnant	Office visits	Prenatal care: No charge Postnatal care: 20% coinsurance	Prenatal care: No charge Postnatal care: 20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	None
	Rehabilitation services	20% coinsurance for occupational therapy, physical therapy, and speech therapy	20% coinsurance for occupational therapy, physical therapy, and speech therapy	None
	Habilitation services	20% coinsurance for occupational therapy, physical therapy, and speech therapy	20% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	20% coinsurance	20% coinsurance	Combined 120 days per person per benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice service	20% 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: 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) (and children)
- Hearing aids (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- 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 x 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, 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 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, kwiijigo holne' 1-855-902-2583.

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 prenatal care and a hospital delivery)

The plan's overall deductible	**$500**
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$770**

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

The plan's overall deductible	**$500**
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$100
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$920**

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

The plan's overall deductible	**$500**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$500
Copayments	$0
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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

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)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

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

နမ့်ကတိၤကညီကျိာ်ဒီး. တ၀်ကဟ့ဉ်နၤကျိာ်တ၀်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTYအဂိၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
WACONIA INDEPENDENT SCHOOL DISTRICT NO 110

Coverage Period: Beginning on or after 07/01/2022
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 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	Answers	Why this Matters:
What is the overall deductible?	**$1,750** individual / **$3,500** family medical combined in-network and out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. 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.
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?	**$3,000** individual / **$6,000** family medical and drug combined in-network and 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, 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 toward the out-of-pocket limit.

Will you pay less if you use an in-network provider?	Yes. Your network is Aware. See https://www.bluecrossmnonline.com/find-a-doctor/#/home 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 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	20% coinsurance	20% coinsurance	None
	Specialist visit	20% coinsurance	20% coinsurance	None
	Preventive care/screening/ immunization	No charge	Well child: No charge Adult: 0% coinsurance; deductible does not apply	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)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.bluecrossmnonline.com	Preferred generic drugs	$20.00 copay/prescription (retail) $40.00 copay/prescription (mail service) $40.00 copay/prescription (90dayRx retail)	$20.00 copay/prescription (retail)	Covers up to a 34-day supply, or 100 units, whichever is greater (retail prescription). 90-day supply (mail order prescription and 90dayRx retail prescription). No coverage for mail order and 90dayRx retail services from out-of-network providers. Insulin listed on the preferred generic/preferred brand prescription drug list are covered at zero cost-sharing.
	Preferred brand drugs	$35.00 copay/prescription (retail) $70.00 copay/prescription (mail service) $70.00 copay/prescription (90dayRx retail)	$35.00 copay/prescription (retail)	
	Non-preferred drugs	Non-preferred generic drugs:	Non-preferred generic drugs:	

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)	
		$50.00 copay/prescription (retail) $100.00 copay/prescription (mail service) $100.00 copay/prescription (90dayRx retail) Non-preferred brand drugs: $50.00 copay/prescription (retail) $100.00 copay/prescription (mail service) $100.00 copay/prescription (90dayRx retail)	$50.00 copay/prescription (retail) Non-preferred brand drugs: $50.00 copay/prescription (retail)	
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	Covers up to a 34-day supply (participating specialty drug network supplier prescription).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance for outpatient hospital facility & ambulatory surgery center	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance for outpatient hospital facility & ambulatory surgery center	20% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible and out-of-pocket limit.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fee	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance use services	Outpatient services	20% coinsurance	20% coinsurance	None
	Inpatient services including residential adult mental health treatment	20% coinsurance	20% coinsurance	

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 are pregnant	Office visits	Prenatal care: No charge Postnatal care: 20% coinsurance	Prenatal care: No charge Postnatal care: 20% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	None
	Rehabilitation services	20% coinsurance for occupational therapy, physical therapy, and speech therapy	20% coinsurance for occupational therapy, physical therapy, and speech therapy	None
	Habilitation services	20% coinsurance for occupational therapy, physical therapy, and speech therapy	20% coinsurance for occupational therapy, physical therapy, and speech therapy	
	Skilled nursing care	20% coinsurance	20% coinsurance	Combined 120 days per person per benefit period.
	Durable medical equipment	20% coinsurance	20% coinsurance	None
	Hospice service	20% 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: 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.)

- Acupuncture
- Cosmetic surgery
- Dental care (Adult) (and children)
- Hearing aids (Adult)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)

- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Private-duty nursing
- 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 x 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, 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 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, kwiijigo holne' 1-855-902-2583.

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 prenatal care and a hospital delivery)

The plan's overall deductible	**$1,750**
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)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$10
Coinsurance	$1,200
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,020**

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

The plan's overall deductible	**$1,750**
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)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$100
Coinsurance	$40
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,910**

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

The plan's overall deductible	**$1,750**
Specialist coinsurance	**20%**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic tests *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,750
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,850**

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

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)
- or by mail at: U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F, HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

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

နမ့်ကတိၤကညီကျိာ်ဒီး. တ၀်ကဟ့ဉ်နၤကျိာ်တ၀်မၤစၢၤကလိတဖဉ်နှဉ်လိၤ. ကိး 1-866-251-6744 လ၊ TTYအဂိၢ်, ကိး 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

BlueCross BlueShield Minnesota

Blue Cross and Blue Shield of Minnesota (Blue Cross)
2022 X21028-R6 Large Group Certificate Amendment

Effective July 1, 2022

The following change is hereby incorporated into the benefit booklet to which this amendment is attached:

The following travel benefits on the Benefit Overview section in the General Provisions chart are hereby added:

General Provisions		
Medical Benefits	**In-Network Providers**	**Out-of-Network Providers**
Lifetime maximum (per member) • If you live more than 100 miles from a provider eligible to perform a termination of pregnancy, there may be a benefit available for travel expenses directly related to covered plan benefits for the procedure	$2,500	
• If you live more than 50 miles from a BDCT provider, there may be a benefit available for travel expenses directly related to a preauthorized transplant.	$5,000	
• If you live more than 50 miles from a pre-approved provider, there may be a benefit available for travel expenses directly related to a pre-authorized gene therapy treatment	$5,000	
For more information about how your benefits for travel expenses work, call Customer Service at the telephone number on the back of your ID card.		

General Provisions			
Medical Benefits	**Enhanced In-Network Providers**	**Standard In-Network Providers**	**Out-of-Network Providers**
Lifetime maximum (per member) • If you live more than 100 miles from a provider eligible to perform a termination of pregnancy, there may be a benefit available for travel expenses directly related to	$2,500		

covered plan benefits for the procedure • If you live more than 50 miles from a BDCT provider, there may be a benefit available for travel expenses directly related to a preauthorized transplant. • If you live more than 50 miles from a pre-approved provider, there may be a benefit available for travel expenses directly related to a pre-authorized gene therapy treatment	$5,000 $5,000
For more information about how your benefits for travel expenses work, call Customer Service at the telephone number on the back of your ID card.	

The following travel benefit on the Maternity Care chart page is hereby added:

Maternity Care – Notes
X. If you live more than 100 miles from a provider eligible to perform a termination of pregnancy, there may be a benefit available for travel expenses directly related to covered plan benefits for the procedure.

The following exclusion on the General Exclusions page is hereby updated:

13. Travel, transportation, or living expenses, whether or not recommended by a physician, except for travel expenses and ambulance transportation listed as covered in the benefit charts and "Benefit Overview."

BlueCross BlueShield Minnesota

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 phone 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 phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

image_0006_NDL_Portrait (09/16)

F10774 (9/16)

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.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

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

နမ့်ကတိၤကညီကျိာ်ဒီး, တ၊်ကဟ့ဉ်နၤကျိာ်တ၊်မၤစၢၤကလီတဖဉ်နှဉ်လီၤ. ကိး 1-866-251-6744 လ၊ TTY အဂိ၊်, ကိး 711 တက့၊်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

አማርኛ የሚናገሩ ከሆነ፣ ነጻ የቋንቋ አገልግሎት እርዳ አለሎት። በ 1-855-315-4030 ይደውሉ ለ TTY በ 711።

한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

ONEDIGITAL