

## Dungarvin Group, Inc.

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

**Coverage Period:** Beginning on or after 09/01/2018

**Coverage for:** Single and 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](http://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 <a href="#">deductible</a> ?	<p><b>\$4,500</b>/individual medical Network  <b>\$9,000</b>/family medical Network  <b>\$5,500</b>/individual medical Out-of-Network  <b>\$10,400</b>family medical Out-of-Network</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. This <a href="#">plan</a> has an embedded <a href="#">deductible</a>. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
Are there services covered before you meet your <a href="#">deductible</a> ?	<p>Yes. Well-child care, prenatal care and Network <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
Are there other <a href="#">deductibles</a> for specific services?	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<p><b>\$6,350</b>/individual medical and drugs Network  <b>\$12,700</b>/family medical and drugs Network  <b>\$9,000</b>/individual medical and drugs Out-of-Network  <b>\$18,000</b>/family medical and drugs Out-of-Network</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>
What is not included in the <a href="#">out-of-pocket limit</a> ?	<p><a href="#">Premiums</a>, <a href="#">balance-billing</a> charges, deductible carryover, emergency room copayment, and health care this <a href="#">plan</a> doesn't cover.</p>	<p>Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a>.</p>

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

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
If you visit a health care <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	\$35 office visit <a href="#">copay</a> ; 40% <a href="#">coinsurance</a> for all other services	60% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$35 office visit <a href="#">copay</a> ; 40% <a href="#">coinsurance</a> for all other services	60% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	60% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services you need are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. No coverage for services from <a href="#">out-of-network providers</a> .
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	0% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you need drugs to treat your illness or condition. A Retail Pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A Mail Service Pharmacy	Generic drugs	\$15.00 <a href="#">copayment</a> /retail \$30.00 <a href="#">copayment</a> /mail service \$30.00 <a href="#">copayment</a> /90dayRx Retail	60% <a href="#">coinsurance</a> /retail Not covered mail service and 90dayRx Retail	Covers up to a 31-day supply (retail prescription); 90-day supply (mail order prescription and 90dayRx Retail prescription).
	Preferred brand drugs	\$60.00 <a href="#">copayment</a> /retail \$120.00 <a href="#">copayment</a> /mail service \$120.00 <a href="#">copayment</a> /90dayRx Retail	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is available at <a href="http://www.bluecrossmnonline.com">www.bluecrossmnonline.com</a>	Non-preferred brand drugs	\$90.00 <a href="#">copayment</a> /retail \$180.00 <a href="#">copayment</a> /mail service \$180.00 <a href="#">copayment</a> /90dayRx Retail	Not covered	Up to a maximum liability of \$200 per prescription for specialty drugs. Covers up to a 31-day supply (participating Specialty Drug Network Supplier prescription). No coverage for services from <a href="#">out-of-network providers</a> .
	<a href="#">Specialty drugs</a>	Refer to applicable prescription drug <a href="#">cost sharing</a>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	None
	<a href="#">Emergency medical transportation</a>	40% <a href="#">coinsurance</a>	40% <a href="#">coinsurance</a>	
	<a href="#">Urgent care</a>	\$65 <a href="#">copay</a> /visit	\$65 <a href="#">copay</a> /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	Services for marriage/couples counseling are not covered.
	Inpatient services	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
If you are pregnant	Office visits	Prenatal Care: No charge Postnatal Care: \$35 office visit <a href="#">copay</a> ; 40% <a href="#">coinsurance</a> for all other services	Prenatal Care: 60% <a href="#">coinsurance</a> Postnatal Care: 60% <a href="#">coinsurance</a>	<a href="#">Cost sharing</a> does not apply to certain <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	
	Childbirth/delivery facility services	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	<a href="#">Network</a> : 120 visits per person per plan year. <a href="#">Out-of-network</a> : 60 visits per person per plan year.
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit for occupational therapy \$40 <a href="#">copay</a> /visit for physical therapy \$40 <a href="#">copay</a> /visit for speech therapy	60% <a href="#">coinsurance</a> for occupational therapy 60% <a href="#">coinsurance</a> for physical therapy 60% <a href="#">coinsurance</a> for speech therapy	<a href="#">Network</a> and <a href="#">Out-of-network</a> combined: 20 visits per person per plan year for physical, occupational and speech therapy services.
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit for occupational therapy \$40 <a href="#">copay</a> /visit for physical therapy \$40 <a href="#">copay</a> /visit for speech therapy	60% <a href="#">coinsurance</a> for occupational therapy 60% <a href="#">coinsurance</a> for physical therapy 60% <a href="#">coinsurance</a> for speech therapy	<a href="#">Network</a> and <a href="#">Out-of-network</a> combined: 20 visits per person per plan year for physical, occupational and speech therapy services.
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	None
	<a href="#">Durable medical equipment</a>	40% <a href="#">coinsurance</a>	60% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	80% <a href="#">coinsurance</a>	None
	<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	20% <a href="#">coinsurance</a>
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 <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture (except as specified in <a href="#">plan</a> benefits)</li> <li>Bariatric Surgery</li> <li>Cosmetic Surgery (except as specified in <a href="#">plan</a> benefits)</li> </ul>	<ul style="list-style-type: none"> <li>Dental Care (except as specified in <a href="#">plan</a> benefits)</li> <li>Infertility Treatment</li> <li>Long-Term Care</li> </ul>	<ul style="list-style-type: none"> <li>Routine Foot Care</li> <li>Weight Loss Programs</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"> <li>Chiropractic Care</li> <li>Hearing aids</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>Private Duty Nursing</li> <li>Routine eye care (Adult)</li> </ul>

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://www.HealthCare.gov> or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: your Claims Administrator by calling toll-free 1-866-873-5943 or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform).

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

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet Minimum Value Standards? Yes.**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through MNSure/the Marketplace.

## Notice of Nondiscrimination Practices

**Effective July 18, 2016**

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: [Civil.Rights.Coord@bluecrossmn.com](mailto: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.

နမ့်ကတိကညီကိုင်နီနီ, တၢ်ကဟ့ၣ်နၢက့ၣ်တၢ်မၤစၢၤကလိတဖၣ်န့ၣ်လီၤ. ကိ: 1-866-251-6744 လၢ TTYအဂီၢ်, ကိ: 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.

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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 ຮ່າວ້ບ. 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.

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

Diné k'ehjí yáníłt'i'go saad bee yát'i' éi t'áájíik'e bee níká'a'doowołgo éi ná'ahoot'i'. Kojí éi béésh bee hodíílnih áqíqéqíóqáqéqíá. TTY biniyégo éi íáájí' béésh bee hodíílnih.

—————*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 network prenatal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,500
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

#### This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
 Diagnostic tests (*ultrasounds and blood work*)  
 Specialist visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

Cost Sharing	
Deductibles	\$2,701
Copayments	\$0
Coinsurance	\$3,649
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$6,410</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,500
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,170
Copayments	\$1,205
Coinsurance	\$691
What isn't covered	
Limits or exclusions	\$55
<b>The total Joe would pay is</b>	<b>\$3,122</b>

### Mia's Simple Fracture

(network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$4,000
■ <a href="#">Specialist copayment</a>	\$35
■ Hospital (facility) <a href="#">coinsurance</a>	40%
■ Other <a href="#">coinsurance</a>	40%

#### This EXAMPLE event includes services like:

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

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

Cost Sharing	
Deductibles	\$850
Copayments	\$245
Coinsurance	\$566
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,661</b>

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

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs.

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