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

**ADAMS COMMUNICATIONS COMPANY LLC / DBA ADAMS PUBLISHING GROUP**

**Coverage Period:** Beginning on or after 01/01/2022  
Coverage for: Individual/Family | Plan Type: PPO

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**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](https://www.healthcare.gov/sbc-glossary) or call 1-866-873-5943 to request a copy.

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<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | $1,500 individual / $3,500 family medical in-network  
$3,000 individual / $6,000 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/](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?** | $5,000 individual / $10,000 family medical and drug in-network  
$8,000 individual / $16,000 family medical and drug 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. |

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GE10279322, 25, 103265, 24, 27 - Effective 01/01/2022 - SBC_Version Effective 1/1/2022  
(DOL OMB control number: 1210-0147/Expiration date: 5/31/2022) (HHS – OMB control number 0938-1146/Expiration date: 10/31/2022)

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**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](https://www.bluecrossmnonline.com/find-a-doctor/#/home) or call 1-866-873-5943 for a list of in-network providers.

**Do you need a referral to see a specialist?**

No.

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.

You can see the **specialist** you choose without a **referral**.

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All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What you Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>In-Network Provider</strong></td>
<td><strong>Out-of-Network Provider</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>$50 <strong>copay</strong>/office visit, <strong>deductible</strong> does not apply; no charge for all other services</td>
<td>40% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$75 <strong>copay</strong>/office visit, <strong>deductible</strong> does not apply; no charge for all other services</td>
<td>40% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>Well child: No charge Adult: 40% <strong>coinsurance</strong></td>
<td>You may have to pay for services that aren't preventive. Ask your <strong>provider</strong> if the services needed are preventive. Then check what your <strong>plan</strong> will pay for.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>40% <strong>coinsurance</strong></td>
</tr>
<tr>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>No charge</td>
<td>40% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong> (Benefit Administered by Express Scripts)</td>
<td>Tier 1: Generic Drugs</td>
<td>$20 <strong>copay</strong> retail (up to 31 days) $37.50 <strong>copay</strong> retail (up to 90 days)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2: Preferred Brand Name Drugs</td>
<td>$80 <strong>copay</strong> retail (up to 31 days) $100 <strong>copay</strong> retail (up to 90 days)</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3: Non-Preferred Brand Name Drugs</td>
<td>$100 <strong>copay</strong> retail (up to 31 days) $200 <strong>copay</strong> retail (up to 90 days)</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

Coverage is limited up to a 31-day supply for non-maintenance drugs at retail, and a 90-day supply for maintenance drugs at retail and home delivery; Certain limitations may apply, including, for example: prior authorization, step therapy, quantity limits.

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For more information about limitations and exceptions, see the **plan** or policy document at [www.bluecrossmnonline.com](http://www.bluecrossmnonline.com)
<table>
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<th>What you Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong><a href="https://www.expresscripts.com/">https://www.expresscripts.com/</a></strong></td>
<td>Tier 4: Specialty Drugs</td>
<td>30% <strong>coinsurance</strong> with a $300 maximum (up to 31 days)</td>
<td>Specialty prescriptions are limited up to a 31-day supply and must be filled through Accredo Specialty Pharmacy</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% <strong>coinsurance</strong> for outpatient hospital facility &amp; ambulatory surgery center</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Physician/surgeon fees</td>
<td>25% <strong>coinsurance</strong> for outpatient hospital facility &amp; ambulatory surgery center</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>$500 <strong>copay/visit; deductible does not apply</strong></td>
<td>Out-of-network services apply to the in-network deductible and out-of-pocket limit.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency medical transportation</td>
<td>25% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Urgent care</td>
<td>$150 <strong>copay/office visit, deductible does not apply; no charge for all other services</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Physician/surgeon fee</td>
<td>25% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use services</td>
<td>Outpatient services</td>
<td>$50 <strong>copay/office visit, deductible does not apply; no charge for all other services</strong></td>
<td>Services for marriage/couples counseling are not covered.</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use services</td>
<td>Inpatient services including residential adult mental health treatment</td>
<td>25% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>Prenatal care: No charge Postnatal care: $50 **copay/primary care office visit or $75 <strong>copay/specialist office visit; deductible does not apply; 25% <strong>coinsurance</strong> for all other services</strong></td>
<td>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).</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Childbirth/delivery professional services</td>
<td>25% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>In-Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>---------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Home health care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>25% coinsurance for occupational therapy, physical therapy, and speech therapy</td>
<td>40% coinsurance for occupational therapy, physical therapy, and speech therapy</td>
<td>None</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Hospice service</td>
<td>25% coinsurance</td>
<td>40% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

**If you need help recovering or have other special health needs**

| Children’s eye exam                          | No charge                                         | Age 0 through 5: No charge                  | None                                            |                                                        |
|                                              |                                                   | Age 6 through 18: 40% coinsurance           |                                                |                                                        |
| 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 (except as specified in plan benefits)
- Dental care (except as specified in plan benefits)
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.):**

- Bariatric surgery
- Hearing aids for individuals 18 year of age or younger
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Chiropractic care
- Infertility treatment
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:
Navajo (Dine): Dine'ehgo shika at'ohwol ninisingo, kwijjigo holne’ 1-855-902-2583.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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About these Coverage Examples:

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

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network prenatal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
<td><strong>The plan's overall deductible</strong></td>
</tr>
<tr>
<td>$1,500</td>
<td>$1,500</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Specialist copay</strong></td>
<td><strong>Specialist copay</strong></td>
<td><strong>Specialist copay</strong></td>
</tr>
<tr>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
<td><strong>Hospital (facility) coinsurance</strong></td>
</tr>
<tr>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
<td><strong>Other coinsurance</strong></td>
</tr>
<tr>
<td>25%</td>
<td>25%</td>
<td>25%</td>
</tr>
</tbody>
</table>

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 | $1,500
- Copayments | $10
- Coinsurance | $2,000
- What isn't covered | 
- Limits or exclusions | $60
- The total Peg would pay is | $3,570

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 | $800
- Copayments | $1,000
- Coinsurance | $0
- What isn't covered | 
- Limits or exclusions | $20
- The total Joe would pay is | $1,820

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 | $1,300
- Copayments | $100
- Coinsurance | $0
- What isn't covered | 
- Limits or exclusions | $20
- The total Mia would pay is | $1,400

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

For more information about limitations and exceptions, see the plan or policy document at [www.bluecrossmnonline.com](http://www.bluecrossmnonline.com)
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


For more information about limitations and exceptions, see the plan or policy document at www.bluecrossmnonline.com
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.


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

اذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 23912-569-866. للهاتف النصي اتصل بالرقم 711.


Afaan Oromoo dubbattu yoo ta'e, tajaaajila gargaarsa afaan hiikoo kaffaltii malee. Argachuu 1-855-315-4016 bibilaa. TTY dhaaf, 711 bibilaa.

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 телефона 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.

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

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

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.


버추어 어시스트처를 받으실 경우, 비영어 서비스가 제공됩니다. 1-855-902-2583으로 TTY를 이용하실 수 있습니다.

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.