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, call (218) 724-8883 or 877-908-FUND (3863). 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/sbcglossary or call (218) 724-8883 or 877-908-FUND (3863) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$400/Family	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, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. 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?	Yes. $25 individual / $75 family deductible for dental coverage B and C. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	Major Medical: $3,400 family Prescription Drug: $4,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Copayments on certain services, premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. Visit bluecrossmnonline.com or call 1-800-810-BLUE (2583) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (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	$25 copay/office visit and 20% coinsurance for other outpatient services	Same as in-network, but may pay balance billing	*General plan limitations may apply. $25 copay does not apply toward the family deductible. Doctor on Demand telehealth visits are covered at 100%, other telehealth visits are paid as listed under the Schedule of Benefits.
	Specialist visit			
	Preventive care/screening/ immunization	No charge for preventive care, $25 copay for office visit may apply		You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive, then check what the plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	Same as in-network, but may pay balance billing	General plan limitations may apply.
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition More information about prescription drug coverage is available by calling (218) 724-8883 or 877-908-FUND (3863).	Generic drugs	20% coinsurance	20% coinsurance	Covers up to a 34-day supply for retail (90-day supply for maintenance drugs). Does not apply toward the family deductible.
	Preferred brand drugs			
	Non-preferred brand drugs			
	Specialty drugs	20% coinsurance or $0-$35 copayment if covered under Flex Access program	Not covered	Covers up to a 34-day supply for specialty drugs. Does not apply toward the family deductible.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Same as in-network, but may pay balance billing	General plan limitations may apply.
	Physician/surgeon fees	$25 copay/office visit and 20% coinsurance		
If you need immediate medical attention	Emergency room care	$100 copay, 20% coinsurance	Same as in-network, you will not pay balance billing	$100 copay may be waived if admitted.
	Emergency medical transportation	20% coinsurance	Same as in-network, but may pay balance billing	*General plan limitations may apply. You will not pay balance billing if the emergency medical transportation is via air ambulance.

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 (You will pay the most)	
	Urgent care	$25 copay/office visit and 20% coinsurance	Same as in network, but may pay balance billing.	*General plan limitations may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Same as in-network, but may pay balance billing	General plan limitations may apply.
	Physician/surgeon fees	$25 copay/office visit and 20% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$25 copay/office visit and 20% coinsurance	Same as in-network, but may pay balance billing	General plan limitations may apply.
	Inpatient services	20% coinsurance		
If you are pregnant	Office visits	$25 copay/office visit and 20% coinsurance	Same as in-network, but may pay balance billing	Cost sharing does not apply for preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in this SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% coinsurance		
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Same as in-network, but may pay balance billing	General plan limitations may apply.
	Rehabilitation services			Limit of 12 chiropractic visits/year, 10 visits/year for physical, speech and occupational therapy
	Habilitation services	Not covered		
	Skilled nursing care	20% coinsurance	Same as in-network, but may pay balance billing	General plan limitations may apply.
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children's eye exam	No charge	Same as in-network, but may pay balance billing	One vision exam per calendar year for children age 18 and younger.
	Children's glasses			One frame and pair of lenses every two years for children age 18 and younger.
	Children's dental check-up	30% coinsurance		Limited to twice per calendar year. Only available for dependents of Groups I, II, III, V age 18 and younger.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery (unless medically necessary)
- Cosmetic surgery (unless due to accident)
- Hearing aids (except when medically necessary due to growth, tumor or other disease)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (unless required due to diagnosis of disease or illness)
- Weight loss programs

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

- Chiropractic care
- Dental care (Adult) – Limited to Group I, II, III and V employees
- Routine eye care (Adult) – Limited to Group I employees

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: Department of Labor's Employee Benefits Security Administration 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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.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: Fund Office (218) 724-8883 or 877-908-FUND (3863); or the Department of Labor's Employee Benefits Security Administration 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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

About these Coverage Examples:

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

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$400
Specialist coinsurance	$25
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	$400
Copayments	$0
Coinsurance	$2,350
What isn't covered	
Limits or exclusions	$50
The total Peg would pay is	$2,800

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

The plan's overall deductible	$400
Specialist coinsurance	$25
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	$350
Copayments	$150
Coinsurance	$850
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	$1,400

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

The plan's overall deductible	$400
Specialist coinsurance	$25
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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

Total Example Cost	$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$75
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$825

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