



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 <u>deductible</u> ?	\$600/Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	Yes. \$25 individual / \$75 family <u>deductible</u> for dental coverage B and C. There are no other specific <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	Major Medical: \$3,400 family Prescription Drug: \$4,500 family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments on certain services</u> , <u>premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. Visit bluecrossmnonline.com or call 1-800-810-BLUE (2583) for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the provider's charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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. 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.
	Specialist visit			
	Preventive care/screening/immunization	No charge for preventive care , \$25 copay for office visit may apply		
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 , subject to adjustment where manufacturer assistance is available or where brand is selected over generic equivalent	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		Not covered	Covers up to a 34-day supply for specialty drugs. Does not apply toward the family deductible .
	Specialty drugs			
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	\$300 copay , 20% coinsurance	Same as in-network , you will not pay balance billing	\$300 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 <u>copay</u> /office visit and 20% <u>coinsurance</u>	Same as <u>in network</u> , but may pay <u>balance billing</u> .	*General <u>plan</u> limitations may apply.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Same as <u>in-network</u> , but may pay <u>balance billing</u>	General <u>plan</u> limitations may apply.
	Physician/surgeon fees	\$25 <u>copay</u> /office visit and 20% <u>coinsurance</u>		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$25 <u>copay</u> /office visit and 20% <u>coinsurance</u>	Same as <u>in-network</u> , but may pay <u>balance billing</u>	General <u>plan</u> limitations may apply.
	Inpatient services	20% <u>coinsurance</u>		
If you are pregnant	Office visits	\$25 <u>copay</u> /office visit and 20% <u>coinsurance</u>	Same as <u>in-network</u> , but may pay <u>balance billing</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in this SBC (e.g., ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>		
	Childbirth/delivery facility services			
If you need help recovering or have other special health needs	Home health care	20% <u>coinsurance</u>	Same as <u>in-network</u> , but may pay <u>balance billing</u>	General <u>plan</u> 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% <u>coinsurance</u>	Same as <u>in-network</u> , but may pay <u>balance billing</u>	General <u>plan</u> limitations may apply.
	Durable medical equipment			
	Hospice services			
If your child needs dental or eye care	Children’s eye exam	No charge	Same as <u>in-network</u> , but may pay <u>balance billing</u>	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	No charge		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](#).)

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| <ul style="list-style-type: none">• Acupuncture• Bariatric surgery (unless medically necessary)• Cosmetic surgery (unless due to accident) | <ul style="list-style-type: none">• 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. | <ul style="list-style-type: none">• Private-duty nursing• Routine foot care (unless required due to diagnosis of disease or illness)• Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

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|---|---|
| <ul style="list-style-type: none">• Chiropractic care• Dental care (Adult) – Limited to Group I, II, III and V employees | <ul style="list-style-type: none">• Routine eye care (Adult) – Limited to Group I employees |
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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	\$600
■ Specialist copayment	\$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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$0
Coinsurance	\$2,350
What isn't covered	
Limits or exclusions	\$50
The total Peg would pay is	\$3,000

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$600
■ Specialist copayment	\$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
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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	\$600
■ Specialist copayment	\$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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$600
Copayments	\$75
Coinsurance	\$325
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000