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) 728-4231 locally, or toll-free 1-877-752-FUND (3863). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copay, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary, call 1-800-318-2596, or call the Fund Office at (218) 728-4231 locally, or toll-free 1-877-752-FUND (3863) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network and Out-of-Network Provider: **$500** Individual / **$1,000** 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 this 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. Preventive care is covered before you meet your deductible. Dental coverage and vision coverage are not subject to any deductible. Unless otherwise specified, the following do not count toward deductible: emergency room deductible; physician office visits; mental health professional office visits; well child care; immunizations; and certain routine screenings.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay 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. **$100** emergency room deductible per sickness visit. **$50** Individual / **$100** Family for Preferred Provider Pharmacy Prescription Drug Benefits. 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? (In- and Out-of-Network limits do not cross accumulate)	Medical: In-Network and Out-of-Network Provider: **$4,600** Individual / **$9,200** Family. For prescription drug coverage: **$2,000** Individual / **$4,000** Family.	The out-of-pocket limit ("OOP") 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, and health care this plan does not cover. Infertility treatment is limited to a $200/year annual limit, which does not count toward the out-of-pocket limit.	Even though you pay these expenses, they don't count toward the out-of-pocket-limit.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. For a list of network providers, visit: www.bluecrossmn.com or call the Fund Office at (218) 728-4231 locally, or toll-free at 1-877-752-FUND (3863).	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 **copay** 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[1]
		Network Provider (You will pay the least)	Non-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, including mental/behavioral health Doctor On Demand and Retail Clinic visits	$35 copay/visit $10 copay/visit	$35 copay/visit $10 copay/visit	In-Network and Out-of-Network: For information on COVID-19 testing-related services with no charge, refer to Section 2.4(I) of the Summary Plan Description.
	Specialist visit	$35 copay / visit	$35 copay / visit	Chiropractic visits limited to 16/year. In-Network and Out-of-Network: 20% coinsurance. Acupuncture care is limited to $500 per calendar year and must be medically necessary. Non-surgical treatment of TMJ is subject to 50% coinsurance and a $900 lifetime limit. Infertility treatment is limited to a $200 annual limit, with 20% coinsurance. In-Network and Out-of-Network: For information on COVID-19 testing-related services described above,

[1] Only the major limitations and exclusions are listed; there may be others. Expenses that are not Medically Necessary are not covered. Maximum limits on the dollar value of benefits do not apply to any item or service that is an Essential Health Benefit. See the SPD or call the Plan Administrator at (218) 728-4231 locally, or toll-free at 1-877-752-FUND (3863) for more information.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*,& Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				refer to Section 2.4(l) of the Summary Plan Description.
	Preventive care/screening/ immunization	No charge	$35 copay/ visit for routine exams; well child care no deductible, $35 copay, then 20% coinsurance; routine immunizations no charge; diagnostic x-ray and lab subject to deductible, 20% coinsurance.	In-Network benefit allowed only for services mandated under the PPACA and described preventive health services by the federal government. If the Plan does not have an In-Network Provider who can provide a particular covered preventive service, then it will cover the item or service without cost sharing when performed by an Out-of-Network Provider acting within the scope of his/her license or certification. 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. In-Network and Out-of-Network: For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	In-Network and Out-of-Network: For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*,& Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.envisionrx.com or by calling 1-800-361-4542.	Generic drugs	10% coinsurance, with a minimum copay of $15 per prescription (retail and mail service)	Not covered	In-Network retail: Covers up to a 90-day supply of generic drugs and up to a 30-day supply for brand name drugs; In-Network mail: 90-day supply for both generic and brand name drugs. Drugs categorized as non-essential by EnvisionRx are not covered. Upon a physician's written prescription, certain prescription medications meeting the USPSTF[1] guidelines for Preventive Health Services, will be covered at a $0 copay through the Preferred Provider Pharmacy Prescription Drug Benefits^; and generic contraceptive products for women available by prescription only (In-Network retail and mail: No charge for generic and single source brand name drugs (retail and mail) and prescription drug deductible does not apply.)
	Preferred brand name drugs	Retail: 20% coinsurance, to a maximum copay of $75 per prescription. Mail: 20% coinsurance, with a minimum/maximum copay of $25/$150 per prescription.	Not covered	
	Non-Preferred brand name drugs	Retail: 20% coinsurance, with a minimum/maximum copay of $35/$150 per prescription. Mail: 20% coinsurance, with a minimum/maximum copay of $70/$300 per prescription.	Not covered	
	Specialty Pharmacy Preferred generic and brand Non-Preferred generic and brand	20% coinsurance; $100 maximum copay 20% coinsurance; $350 maximum copay	Not covered	In-Network Specialty Pharmacy: Covers a 30-day supply

[1] For current USPSTF guidelines, please visit https://www.uspreventiveservicestaskforce.org/.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*,& Other Important Information
		Common Medical Event	Services You May Need	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance	None
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 deductible, then 20% coinsurance	$100 deductible, then 20% coinsurance	Deductible waived if admitted within 24 hours of the visit. Deductible not applicable for injuries. In-Network and Out-of-Network: For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Only transportation to the nearest hospital is covered unless a physician certifies that required treatment is not available at the nearest hospital.
	Urgent care	$35 copay/visit	$35 copay/visit	In-Network and Out-of-Network: For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	Limited to hospital's semi-private room rate (or private room rate when medically necessary). Plan does not cover inpatient out-of-network services, except for the treatment of emergency medical conditions.
	Physician/surgeon fees	20% coinsurance	Not covered	Plan does not cover inpatient out-of-network services, except for the treatment of emergency medical conditions.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit; 20% coinsurance for outpatient services	$35 copay/office visit; 20% coinsurance for outpatient services	None
	Inpatient services	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions*,& Other Important Information[1]
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	$35 copay/visit	$35 copay/visit	None
	Childbirth/delivery professional services	20% coinsurance	Not covered	
	Childbirth/delivery facility services	20% coinsurance	Not covered	
If you need help recovering or have other special health needs	Home health care	$35 copay/visit	$35 copay/visit	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Physical and occupational therapy limited to combined maximum of 15 visits/disability (plus 11 additional visits if prior authorized). Speech therapy limited to 15 visits/disability. For disabilities caused by stroke: 25 visits/disability combined for physical and occupational therapy and 25 visits/disability for speech therapy.
	Habilitation services	Not covered	Not covered	Not covered
	Skilled nursing care	20% coinsurance	20% coinsurance	Limited to 30 days following one period of hospital confinement.
	Durable medical equipment	20% coinsurance	20% coinsurance	Purchase vs. rental if more economical; replacements covered only under certain conditions.
	Hospice services	20% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	20% coinsurance	20% coinsurance	Limited to 1 exam/calendar year. No deductible.
	Children's glasses	50% coinsurance	50% coinsurance	Limited to 1 set of lenses and frames every calendar year. No deductible.
	Children's dental check-up	10% coinsurance of Reasonable and Customary charge	10% coinsurance of Reasonable and Customary charge	Limited to 1 check-up/6 months.

[1] Only the major limitations and exclusions are listed; there may be others. Expenses that are not Medically Necessary are not covered. Maximum limits on the dollar value of benefits do not apply to any item or service that is an Essential Health Benefit. See the SPD or call the Plan Administrator at (218) 728-4231 locally, or toll-free at 1-877-752-FUND (3863) for more information.

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.)

- Cosmetic surgery, except for repair of damage due to injury within one year after the date of the accident
- Habilitation services
- Hearing aids
- 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.)

- Acupuncture payable if medically necessary up to $500 per calendar year
- Bariatric surgery, when medically necessary and prior authorized
- Chiropractic care, up to 16 visits/year
- Dental care (Adult and Children)
- Infertility treatment, up to $200/year
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult and Children)

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 the Department of Labor's Employee Benefits Security Administration is 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa. 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, call 1-800-318-2596, or contact the Fund Office at (218) 728-4231 locally, or toll-free at 1-877-752-FUND (3863).

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 the Plan Administrator at (218) 728-4231 locally, or toll-free at 1-877-752-FUND (3863), or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa.

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, copays 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** **$500**
- **Specialist copay** **$35**
- **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
Copays	$10
Coinsurance	$2,330
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,900**

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 copay** **$35**
- **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	$420
Copays	$330
Coinsurance	$800
What isn't covered	
Limits or exclusions	$50
The total Joe would pay is	**$1,600**

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

- **The plan's overall deductible** **$500**
- **Specialist copay** **$35**
- **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	$500
Copays	$100
Coinsurance	$350
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$950**

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