



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:
<b>What is the overall deductible?</b>	<u>In-Network and Out-of-Network Provider:</u> <b>\$500</b> Individual / <b>\$1,000</b> 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 this <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <u>Preventive care</u> is covered before you meet your <u>deductible</u> . Dental coverage and vision coverage are not subject to any <u>deductible</u> . Unless otherwise specified, the following do not count toward <u>deductible</u> : <u>emergency room deductible</u> ; physician office visits; mental health professional office visits; well child care; immunizations; and certain routine <u>screenings</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>copay</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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other deductibles for specific services?</b>	Yes. <b>\$100</b> <u>emergency room deductible</u> per sickness visit. 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.
<b>What is the out-of-pocket limit for this plan?</b>	Medical: <u>In-Network and Out-of-Network Provider:</u> * <b>\$4,600</b> Individual / <b>\$9,200</b> Family. For <u>prescription drug coverage</u> : <b>\$2,000</b> Individual / <b>\$4,000</b> 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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<u>Premiums</u> , <u>balance billing</u> charges, and health care this <u>plan</u> does not cover. Infertility treatment (coverage of which is limited to \$200/year) and extended post-hospital care at home or a skilled nursing home (coverage of which is limited to a maximum of 30 days following one period of hospital confinement) do not count toward the <u>out-of-pocket limit</u> .	Even though you pay these expenses, they don't count toward the <u>out-of-pocket-limit</u> .

Important Questions	Answers	Why This Matters:
Will you pay less if you use a <u>network provider</u> ?	Yes.* For a list of <u>network providers</u> , visit: <a href="http://www.bluecrossmn.com">www.bluecrossmn.com</a> or call the Fund Office at (218) 728-4231 locally, or toll-free at 1-877-752-FUND (3863). <i>*Out-of-network providers are treated as in-network providers for cost sharing purposes in certain circumstances: emergency treatment by an out-of-network provider, services from an out-of-network provider at an in-network facility, and out-of-network air ambulance costs for emergencies.</i>	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 <u>provider's charge</u> 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 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 <sup>1</sup>
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a <u>health care provider's office</u> or clinic	Primary care visit to treat an injury or illness, including mental/behavioral health	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	<u>In-Network</u> and <u>Out-of-Network</u> : For information on COVID-19 testing-related services with no charge, refer to Section 2.4(l) of the Summary Plan Description.
	Doctor On Demand and Retail Clinic visits	\$10 <u>copay</u> /visit	\$10 <u>copay</u> /visit	
	<u>Specialist</u> visit	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	Chiropractic visits limited to 16/year. <u>In-Network</u> and <u>Out-of-Network</u> : 20% <u>coinsurance</u> . Acupuncture care is limited to \$500 per calendar year and must be <u>medically necessary</u> . Non-surgical treatment of TMJ is subject to 50% <u>coinsurance</u> and a \$900 lifetime limit. Infertility treatment is limited to a \$200

<sup>1</sup> 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 <sup>1</sup>
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
				annual limit, with 20% <u>coinsurance</u> . <u>In-Network</u> and <u>Out-of-Network</u> : For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
	<u>Preventive care/screening/immunization</u>	No charge	\$35 <u>copay</u> /visit for routine exams; well child care no <u>deductible</u> , \$35 <u>copay</u> , then 20% <u>coinsurance</u> ; routine immunizations no charge; diagnostic x-ray and lab subject to <u>deductible</u> , 20% <u>coinsurance</u> .	<u>In-Network</u> benefit allowed only for services mandated under the PPACA and described as <u>preventive services</u> by the federal government. If the <u>Plan</u> does not have an <u>In-Network Provider</u> who can provide a particular covered <u>preventive service</u> , then it will cover the item or service without <u>cost sharing</u> when performed by an <u>Out-of-Network Provider</u> acting within the scope of his/her license or certification. You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for. <u>In-Network</u> and <u>Out-of-Network</u> : For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
<b>If you have a test</b>	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	<u>In-Network</u> and <u>Out-of-Network</u> : 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% <u>coinsurance</u>	20% <u>coinsurance</u>	None

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

<sup>1</sup> 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
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	\$100 <u>deductible</u> , then 20% <u>coinsurance</u>	\$100 <u>deductible</u> , then 20% <u>coinsurance</u>	<u>Deductible</u> waived if admitted within 24 hours of the visit. <u>Deductible</u> not applicable for injuries. <u>In-Network</u> and <u>Out-of-Network</u> : For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Only transportation to the nearest hospital is covered unless a physician certifies that required treatment is not available at the nearest hospital.
	<u>Urgent care</u>	\$35 <u>copay/visit</u>	\$35 <u>copay/visit</u>	<u>In-Network</u> and <u>Out-of-Network</u> : For information on COVID-19 testing-related services described above, refer to Section 2.4(l) of the Summary Plan Description.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% <u>coinsurance</u>	Not covered	Limited to hospital's semi-private room rate (or private room rate when <u>medically necessary</u> ). Plan does not cover inpatient <u>out-of-network</u> services, except for emergency treatment.
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	Plan does not cover inpatient <u>out-of-network</u> services, except for emergency treatment. <i>(Please refer to page 2 regarding circumstances when <u>out-of-network providers</u> are treated as <u>in-network providers</u> for <u>cost sharing</u> purposes.)</i>
<b>If you need mental health, behavioral health, or substance abuse services</b>	Outpatient services	\$35 <u>copay/office visit</u> ; 20% <u>coinsurance</u> for outpatient services	\$35 <u>copay/office visit</u> ; 20% <u>coinsurance</u> for outpatient services	None
	Inpatient services	20% <u>coinsurance</u>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information <sup>1</sup>
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	<u>Cost sharing</u> does not apply for <u>preventive services</u> .
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	\$35 <u>copay</u> /visit	\$35 <u>copay</u> /visit	None
	<u>Rehabilitation services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	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.
	<u>Habilitation services</u>	Not covered	Not covered	Not covered
	<u>Skilled nursing care</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 30 days following one period of hospital confinement.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Purchase vs. rental if more economical; replacements covered only under certain conditions.
	<u>Hospice services</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	20% <u>coinsurance</u>	20% <u>coinsurance</u>	Limited to 1 exam/calendar year. No <u>deductible</u> .
	Children's glasses	50% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 set of lenses and frames every calendar year. No <u>deductible</u> .
	Children's dental check-up	10% <u>coinsurance</u> of Reasonable and Customary charge	10% <u>coinsurance</u> of Reasonable and Customary charge	Limited to 1 check-up/6 months.

<sup>1</sup> 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](http://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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
---------------------------	-----------------

In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copays</u>	\$10
<u>Coinsurance</u>	\$2,330
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,900</b>

**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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$350
<u>Copays</u>	\$350
<u>Coinsurance</u>	\$750
<i>What isn't covered</i>	
Limits or exclusions	\$50
<b>The total Joe would pay is</b>	<b>\$1,500</b>

**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*)

<b>Total Example Cost</b>	<b>\$2,800</b>
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$500
<u>Copays</u>	\$100
<u>Coinsurance</u>	\$350
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$950</b>

This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above. The plan would be responsible for the other costs of these EXAMPLE covered services.