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: $600 Individual / $1,800 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. 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. 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:* $5,600 Individual / $11,000 Family.<br>For prescription drug coverage: $3,000 Individual / $5,000 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, 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 (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 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).<br>**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.* | 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 | 20% coinsurance/visit | 20% coinsurance/visit | Plan does not cover Out-of-Network telehealth visits. |
| | Doctor On Demand and Retail Clinic visits | 20% coinsurance/visit | 20% coinsurance/visit | |
| | Specialist visit | 20% coinsurance/visit | 20% coinsurance/visit | Chiropractic visits limited to 16/year. In-Network and Out-of-Network: 20% coinsurance. Acupuncture care is limited to $500 |

[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) | |
| | | | | 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. |
| | Preventive care/screening/ immunization | No charge | 20% coinsurance/visit for routine exams; well child care no deductible, 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 as preventive 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. |
| If you have a test | Diagnostic test (x-ray, blood work) | 20% coinsurance | 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 20% coinsurance | None |

| | | | | |
|---|---|---|---|---|
| If you need drugs to treat your illness or condition<br><br>More information about prescription drug coverage is available at www.elixirsolutions.com or by calling 1-800-361-4542. | Generic drugs | Retail: $15 copay or 10% coinsurance per prescription<br><br>90 Retail &/or Mail: 10% coinsurance with minimum $15 copay | Not covered | In-Network retail: Covers up to a 90-day supply of generic drugs and brand name drugs, including maintenance drugs; In-Network mail: 90-day supply for both generic and brand name drugs (including maintenance drugs) through BirdiRxMail. Maintenance drugs must be filled for a 90-day supply and filled through BirdiRxMail. Drugs categorized as non-essential by MedImpact are not covered.<br><br>Upon a physician's written prescription, certain prescription medications meeting the USPSTF[1] guidelines for Preventive 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). |
| | Preferred brand name drugs | Retail: 20% coinsurance, max. $75 copay per prescription.<br><br>90 Retail &/or Mail: 20% coinsurance, with a min/max. copay of $25/$150 per prescription. | Not covered | |
| | Non-Preferred brand name drugs | Retail: 20% coinsurance, with a min./max. copay of $35/$150 per prescription.<br><br>90 Retail &/or Mail: 20% coinsurance, with a min./max. copay of $70/$300 per prescription. | Not covered | |
| | Specialty Pharmacy<br><br>Preferred generic and brand<br><br>Non-Preferred generic and brand | <br><br>20% coinsurance; $100 max. copay<br><br>20% coinsurance; $350 max. copay | Not covered | In-Network: Specialty Pharmacy: Covers a 30-day supply. |
| 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 |

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

| | | | | |
|---|---|---|---|---|
| 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. |
| | 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 | 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. |
| 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 emergency treatment. |
| | Physician/surgeon fees | 20% coinsurance | Not covered | Plan does not cover inpatient out-of-network services, except for emergency treatment. *(Please refer to page 2 regarding circumstances when out-of-network providers are treated as in-network providers for cost sharing purposes.)* |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 20% coinsurance | 20% coinsurance | None |
| | Inpatient services | 20% coinsurance | Not covered | None |

| | | | | |
|---|---|---|---|---|
| If you are pregnant | Office visits | 20% coinsurance | 20% coinsurance | Cost sharing does not apply for preventive services. |
| | 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 | 20% coinsurance | 20% coinsurance | 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 | Not covered | Not covered | Not covered |
| | Children's glasses | Not covered | Not covered | Not covered |
| | Children's dental check-up | Not covered | Not covered | Not covered |

## 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
- Dental care
- Habilitation services
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care
- 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
- Infertility treatment, up to $200/year
- Non-emergency care when traveling outside the U.S.

**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.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-535-6373, alternativamente, (952) 854-0795.

*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 | $600 |
| Specialist copay | $0 |
| 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 | $600 |
| Copays | $10 |
| Coinsurance | $2,300 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| The total Peg would pay is | $2,970 |

### 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 copay | $0 |
| 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 |
| Copays | $120 |
| Coinsurance | $980 |
| *What isn't covered* | |
| Limits or exclusions | $50 |
| The total Joe would pay is | $1,500 |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist copay | $0 |
| 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 | $600 |
| Copays | $5 |
| Coinsurance | $450 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| The total Mia would pay is | $1,050 |

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.