




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 (952) 854-0795 or (800) 535-6373. 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/sbc-glossary/> or call (952) 854-0795 or (800) 535-6373 to request a copy.

Important Questions	Answers	Why This Matters:
<p>What is the overall <a href="#">deductible</a>?</p>	<p>Combined <a href="#">in-network</a> and <a href="#">out-of-network</a>: \$500/individual or \$1,500/family</p>	<p>Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a>, each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p>Are there services covered before you meet your <a href="#">deductible</a>?</p>	<p>Yes. <a href="#">In-Network</a> services for Autism treatment, telehealth visits, mental health, substance abuse, inpatient hospital facility fees (including <a href="#">medically necessary</a> dental care), newborn expenses, <a href="#">prescription drug</a>, <a href="#">preventive care</a>, convenience clinics and transplant facility fees are covered before you meet your <a href="#">deductible</a>. <a href="#">Out-of-Network</a> services for newborn expenses are covered before you meet your <a href="#">deductible</a>.</p>	<p>This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount, but a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">in-network preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a>. See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</p>
<p>Are there other <a href="#">deductibles</a> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</p>	<p>Medical <a href="#">in-network</a> and <a href="#">out-of-network</a> combined: \$2,500/individual or \$5,000/family Prescription Drugs <a href="#">in-network</a> only: \$3,000/individual or \$7,000/family</p>	<p>The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a>, they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.</p>

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Copayments</a> for Dental and Vision Benefits, <a href="#">deductible</a> , <a href="#">premiums</a> , <a href="#">balance billing</a> charges, penalties for failure to obtain required <a href="#">precertification</a> and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See or call BCBS of Minnesota at (800) 810-2583 or <a href="http://www.bluecrossonline.com">www.bluecrossonline.com</a> for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	<a href="#">In-Network</a> Telehealth visits (Doctor on Demand) and Convenience Clinics covered at no <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> . <a href="#">Out-of-Network</a> covered at 25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a> .  You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
	<a href="#">Specialist</a> visit			
	<a href="#">Preventive care/screening/</a> Immunization	No charge	Not covered	
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	-----none-----
	Imaging (CT/PET scans, MRIs)			

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)	
<p><b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.myprime.com">www.myprime.com</a> or by calling Wilson-McShane at (800) 535-6373.</p>	Generic drugs	Retail (34 day supply): 20% <a href="#">coinsurance</a> with \$10 minimum and \$50 maximum Mail Order or Retail (90 day supply): 15% <a href="#">coinsurance</a> with \$25 minimum and \$125 maximum	Not covered	<p>90 day supply also available at all retail 90 day contracted pharmacies. There is no coverage at Walmart or Sam's Club pharmacies.</p> <p>Step Therapy, Prior Authorization and other cost and benefit management programs apply for certain medications.</p>
	<a href="#">Formulary</a> brand drugs	Retail (34 day supply): 30% <a href="#">coinsurance</a> with \$25 minimum and \$150 maximum Mail Order or Retail (90 day supply): 25% <a href="#">coinsurance</a> with \$62.50 minimum and \$375 maximum		
	Non- <a href="#">formulary</a> brand drugs	25% <a href="#">coinsurance</a> with \$62.50 minimum and \$375 maximum; 34 day supply limit		
	<a href="#">Specialty drugs</a>			
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	<a href="#">Precertification</a> is required for some surgeries.
	Physician/surgeon fees			-----none-----
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$200 <a href="#">copayment</a> /visit plus 15% <a href="#">coinsurance</a>	\$200 <a href="#">copayment</a> plus 15% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	\$200 <a href="#">copayment</a> waived if Covered Person is admitted to the hospital within 48 hours.
	<a href="#">Emergency medical transportation</a>	15% <a href="#">coinsurance</a>	15% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	-----none-----
	<a href="#">Urgent care</a>	\$25 <a href="#">copayment</a> /visit plus 15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	<a href="#">In-Network</a> Telehealth visits (Doctor on Demand) and Convenience Clinics covered at no <a href="#">copayment</a> , <a href="#">deductible</a> or <a href="#">coinsurance</a> . <a href="#">Out-of-Network</a> covered at 25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a> .

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 have a hospital stay	Facility fee (e.g., hospital room)	15% <a href="#">coinsurance</a> no <a href="#">deductible</a>	Not covered	<a href="#">Precertification</a> is required.
	Physician/surgeon fees	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	-----none-----
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% <a href="#">coinsurance</a> no <a href="#">deductible</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	-----none-----
	Inpatient services	15% <a href="#">coinsurance</a> no <a href="#">deductible</a>	Not covered	
If you are pregnant	Office visits	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	<a href="#">Cost sharing</a> does not apply to <a href="#">preventive services</a> . Depending on the type of services, <a href="#">coinsurance</a> or a <a href="#">deductible</a> may apply. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound).
	Childbirth/delivery professional services	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	
	Childbirth/delivery facility services	15% <a href="#">coinsurance</a> no <a href="#">deductible</a>	Not covered	<a href="#">In-Network</a> and <a href="#">Out-of-Network</a> newborn expenses are covered at the appropriate <a href="#">coinsurance</a> level with no <a href="#">deductible</a> . In-patient stay of at least 48 hours for the mother and newborn child following a vaginal delivery or at least 96 hours for the mother and newborn child following a cesarean section delivery.

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 need help recovering or have other special health needs	<a href="#">Home health care</a>	15% <a href="#">coinsurance</a>	25% <a href="#">coinsurance</a> of the <a href="#">allowed amount</a>	<a href="#">Precertification</a> is required. Maximum of 180 home visits in any 12 consecutive months from all <a href="#">providers</a> . Benefit cannot exceed cost of care in skilled nursing facility.
	<a href="#">Rehabilitation services</a>			-----none-----
	<a href="#">Habilitation services</a>			-----none-----
	<a href="#">Skilled nursing care</a>			<a href="#">Precertification</a> is required. Limit of 365 days per confinement.
	<a href="#">Durable medical equipment</a>			<a href="#">Precertification</a> is required for some <a href="#">durable medical equipment</a> . \$350 annual maximum for wigs due to Alopecia Areata.
	<a href="#">Hospice services</a>			<a href="#">Precertification</a> is required.
If your child needs dental or eye care	Children's eye exam	No charge after \$15 <a href="#">copayment</a> /visit	No charge up to \$45	Vision care is administered through VSP.
	Children's glasses	Frames: up to \$130 retail frame allowance Lens: No charge after \$30 <a href="#">copayment</a>	Reimbursement maximums: Frames: up to \$70 Lens: Single vision - \$30 Bifocal - \$50 Trifocal - \$65 Lenticular - \$100	
	Children's dental check-up	No charge	No charge up to the <a href="#">allowed amount</a>	Dental care is administered through Delta Dental.

## Excluded Services & Other Covered Services:

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery (except when related to accidental injury, sickness or congenital anomaly)</li></ul>	<ul style="list-style-type: none"><li>• Dental care (Adult) – Dental care benefits may be covered by a separate dental plan</li><li>• Infertility treatment</li><li>• Long-term care</li></ul>	<ul style="list-style-type: none"><li>• Private duty nursing</li><li>• Routine foot care</li><li>• Weight loss programs (except those covered under ACA <a href="#">preventive care</a> guidelines)</li></ul>
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)		
<ul style="list-style-type: none"><li>• Bariatric surgery</li><li>• Chiropractic care (In-network only – up to 20 visits per calendar year)</li></ul>	<ul style="list-style-type: none"><li>• Routine eye care (Adult or child)</li><li>• Hearing aids</li></ul>	<ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S.</li></ul>

**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 at (866) 444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](http://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: the Fund Office at (952) 854-0795 or (800) 535-6373 or the Department of Labor's Employee Benefits Security Administration at (866) EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://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](#).

## Language Access Services:

Para obtener asistencia en Español, llame al (952) 854-0795 or (800) 535-6373.

*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](#) \$500
- [Specialist coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$2,370</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 coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$500
<a href="#">Copayments</a>	\$300
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,020</b>

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

- The [plan's](#) overall [deductible](#) \$500
- [Specialist coinsurance](#) 15%
- Hospital (facility) [coinsurance](#) 15%
- Other [coinsurance](#) 15%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$700
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,010</b>

**The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.**