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:
What is the overall deductible?	Combined in-network and out-of-network: $500/individual or $1,500/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 the 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. In-Network services for Autism treatment, telehealth visits, mental health, substance abuse, inpatient hospital facility fees (including medically necessary dental care), newborn expenses, prescription drug, preventive care, convenience clinics and transplant facility fees are covered before you meet your deductible. Out-of-Network services for newborn expenses are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount, but a copayment or coinsurance may apply. For example, this plan covers certain in-network 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Medical in-network and out-of-network combined: $2,500/individual or $5,000/family Prescription Drugs in-network only: $3,000/individual or $7,000/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.

Important Questions	Answers	Why This Matters:
What is not included in the out-of-pocket limit?	Copayments for Dental and Vision Benefits, deductible, premiums, balance billing charges, penalties for failure to obtain required precertification and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See or call BCBS of Minnesota at (800) 810-2583 or www.bluecrossonline.com for a list of network providers.	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 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	15% coinsurance	25% coinsurance of the allowed amount	In-Network Telehealth visits (Doctor on Demand) and Convenience Clinics covered at no copayment, deductible or coinsurance. Out-of-Network covered at 25% coinsurance of the allowed amount.
	Specialist visit			
	Preventive care/screening/ Immunization	No charge	Not covered	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)	15% coinsurance	25% coinsurance of the allowed amount	----------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)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.myprime.com or by calling Wilson-McShane at (800) 535-6373.	Generic drugs	Retail (34 day supply): 20% coinsurance with $10 minimum and $50 maximum Mail Order or Retail (90 day supply): 15% coinsurance with $25 minimum and $125 maximum	Not covered	90 day supply also available at all retail 90 day contracted pharmacies. There is no coverage at Walmart or Sam's Club pharmacies. Step Therapy, Prior Authorization and other cost and benefit management programs apply for certain medications.
	Formulary brand drugs	Retail (34 day supply): 30% coinsurance with $25 minimum and $150 maximum Mail Order or Retail (90 day supply): 25% coinsurance with $62.50 minimum and $375maximum		
	Non-formulary brand drugs			
	Specialty drugs	25% coinsurance with $62.50 minimum and $375 maximum; 34 day supply limit		Specialty drugs limited to 34-day supply: Must be filled only through AllianceRx Walgreens Prime specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	25% coinsurance of the allowed amount	Precertification is required for some surgeries.
	Physician/surgeon fees			----------none----------
If you need immediate medical attention	Emergency room care	$200 copayment/visit plus 15% coinsurance	$200 copayment plus 15% coinsurance of the allowed amount	$200 copayment waived if Covered Person is admitted to the hospital within 48 hours.
	Emergency medical transportation	15% coinsurance	15% coinsurance of the allowed amount	----------none----------
	Urgent care	$25 copayment/visit plus 15% coinsurance	25% coinsurance of the allowed amount	In-Network Telehealth visits (Doctor on Demand) and Convenience Clinics covered at no copayment, deductible or coinsurance. Out-of-Network covered at 25% coinsurance of the allowed amount.

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% coinsurance no deductible	Not covered	Precertification is required.
	Physician/surgeon fees	15% coinsurance	25% coinsurance of the allowed amount	----------none----------
If you need mental health, behavioral health, or substance abuse services	Outpatient services	15% coinsurance no deductible	25% coinsurance of the allowed amount	----------none----------
	Inpatient services	15% coinsurance no deductible	Not covered	
If you are pregnant	Office visits	15% coinsurance	25% coinsurance of the allowed amount	Cost sharing does not apply to preventive services. Depending on the type of services, coinsurance or a deductible may apply. Maternity care may include tests and services described elsewhere in this document (i.e. ultrasound). In-Network and Out-of-Network newborn expenses are covered at the appropriate coinsurance level with no deductible.
	Childbirth/delivery professional services	15% coinsurance	25% coinsurance of the allowed amount	
	Childbirth/delivery facility services	15% coinsurance no deductible	Not covered	In-Network and Out-of-Network newborn expenses are covered at the appropriate coinsurance level with no deductible. 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	Home health care	15% coinsurance	25% coinsurance of the allowed amount	Precertification is required. Maximum of 180 home visits in any 12 consecutive months from all providers. Benefit cannot exceed cost of care in skilled nursing facility.
	Rehabilitation services			----------none----------
	Habilitation services			----------none----------
	Skilled nursing care			Precertification is required. Limit of 365 days per confinement.
	Durable medical equipment			Precertification is required for some durable medical equipment. $350 annual maximum for wigs due to Alopecia Areata.
	Hospice services			Precertification is required.
If your child needs dental or eye care	Children's eye exam	No charge after $15 copayment/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 copayment	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 allowed amount	Dental care is administered through Delta Dental.

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.)

- Acupuncture
- Cosmetic surgery (except when related to accidental injury, sickness or congenital anomaly)
- Dental care (Adult) – Dental care benefits may be covered by a separate dental plan
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine foot care
- Weight loss programs (except those covered under ACA preventive care guidelines)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric surgery
- Chiropractic care (In-network only – up to 20 visits per calendar year)
- Routine eye care (Adult or child)
- Hearing aids
- 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 those agencies is: Department of Labor's Employee Benefits Security Administration at (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: 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.

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

In this example, Peg would pay:

Cost Sharing	
Deductibles	$500
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,370

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

In this example, Joe would pay:

Cost Sharing	
Deductibles	$500
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	$1,020

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

In this example, Mia would pay:

Cost Sharing	
Deductibles	$700
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,010

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