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, contact the Fund Office at (952) 851-5797 or 1-844-468-5917 or visit www.663benefits.com. 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 www.dol.gov/ebsa/healthreform.com or call (952) 851-5797 or 1-844-468-5917 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$750** person/**$2,250** family (January 1 – December 31)	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. Routine physical exams, ACA preventive care, prescription drugs, vision care, dental care, and Doctor on Demand (telemedicine) services 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 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. $25 per person for restorative/prosthetic dental benefits. There are no other specific deductibles. (January 1 – December 31)	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?	Medical: **$3,000** person/**$6,000** family; Prescription drugs: **$3,600** person/**$7,200** family (January 1 – December 31)	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 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 www.umr.com for a list of network providers. **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.

Important Questions	Answers	Why This Matters:
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	$25 copayment/visit, then 20% coinsurance	$25 copayment/visit, then 20% coinsurance	Doctor on Demand (telemedicine) services are covered before you meet your deductible.
	Specialist visit	Chiropractor: $25 copayment/visit then 20% coinsurance Other specialists: $50 copayment/visit, then 20% coinsurance	Chiropractor: $25 copayment/visit then 20% coinsurance Other specialists: $50 copayment/visit, then 20% coinsurance	Chiropractic care limited to 20 visits per person per calendar year (limit includes acupuncture visits for pain relief).
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	No charge. Deductible does not apply.	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	No charge and the deductible does not apply for x-ray and/or lab work performed in connection with a routine physical exam.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com.	Generic and brand name drugs	20% coinsurance (retail and mail order). Deductible does not apply.	Not covered	No charge for ACA-required generic preventive drugs (such as contraceptives) (or brand drug if a generic is not medically appropriate). Prescription drugs must be obtained through Express Scripts or they are not covered. 90-day supply for generic and brand name drugs (retail and mail order). Specialty drugs must be obtained through the specialty drug vendor only. Certain over the counter (OTC) drugs are covered at no charge and the deductible does not apply (retail and mail order) with a physician's written prescription.
	Specialty drugs	20% coinsurance. Deductible does not apply.	Not covered	

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 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	$250 copayment/visit, then 20% coinsurance	$250 copayment/visit, then 20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	Coverage for local ground/air ambulance services to nearest hospital equipped to provide the medically necessary treatment.
	Urgent care	20% coinsurance	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance	Limited to semi-private room rate. Private room rate covered when isolation is medically necessary.
	Physician/surgeon fees	20% coinsurance	20% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: $50 copayment, then 20% coinsurance Other services: 20% coinsurance	Office visit: $50 copayment, then 20% coinsurance Other services: 20% coinsurance	No charge for assessment, short-term counseling, and referral services provided through the Employee Assistance Program. Doctor on Demand (telemedicine) services are covered before you meet your deductible.
	Inpatient services	20% coinsurance	20% coinsurance	
If you are pregnant	Office visits	$50 copayment/visit, then 20% coinsurance	$50 copayment/visit, then 20% coinsurance	20% coinsurance decreased to 10% coinsurance if you enroll in the Maternity Care Program prior to your second trimester of pregnancy and complete the program. Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described somewhere else in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	

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	20% coinsurance	20% coinsurance	None
	Rehabilitation services	20% coinsurance	20% coinsurance	Speech therapy is covered when medically necessary for a condition resulting from an injury, illness or congenital disorder such as cleft lip or palate.
	Habilitation services	Not covered	Not covered	You must pay 100% of this service, even from a network provider.
	Skilled nursing care	20% coinsurance	20% coinsurance	Must be transferred within 24 hours of hospital discharge. Limited to 30 days per confinement. Physician must certify (and re-certify every seven days) that services are medically necessary.
	Durable medical equipment	20% coinsurance	20% coinsurance	Purchase of certain equipment is covered if rental would exceed the purchase price.
	Hospice services	20% coinsurance	20% coinsurance	Must be recommended by physician for terminally ill person.
If your child needs dental or eye care	Children's eye exam	No charge for person under age 19; deductible does not apply. No charge up to $50 for person age 19 and over; deductible does not apply.		You must pay the cost for the exam and then submit a claim for reimbursement. Limited to one exam per calendar year.
	Children's glasses	No charge for lenses for person under age 19; deductible does not apply. For person age 19 and over, no charge up to: $37 per single lens, $64 per bifocal lens, $78 per trifocal lens, $140 per Lenticular lens and $87 per set of contacts; deductible does not apply. No charge up to $70 for frames; deductible does not apply.		Eligible person is limited to one set of lenses and frames or contact lenses per calendar year. You must pay 100% of all expenses over the allowed amounts for lenses and frames or contact lenses.
	Children's dental check-up	No charge. Neither the medical nor the dental deductible applies.	No charge. Neither the medical nor the dental deductible applies.	Dental care calendar year maximum of $1,250 per person does not apply to diagnostic and preventive dental care for individuals under age 19. Eligible person is limited to two dental exams per 12-month period.

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 reconstructive surgery following a mastectomy or to repair a defect caused by an injury or a congenital anomaly) • Habilitation services	• Infertility treatment (only testing to point of diagnosis is covered) • Long-term care • Non-emergency care when traveling outside the U.S.	• Routine foot care (except for custom-molded inserts or orthotics; limited to one pair until worn out and physician prescribes another pair) • Weight loss programs (except as required by the health reform law)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limited to 20 visits per person per calendar year combined with chiropractic care visit) • Bariatric surgery (when medically necessary due to morbid obesity) • Chiropractic care (limited to 20 visits per person per calendar year combined with acupuncture)	• Dental care (Adults) (calendar year maximum of $1,250 per person, except for diagnostic and preventive dental care for individuals under age 19) • Hearing aids ($500 maximum per ear per calendar year; replacement permitted every three years)	• Private-duty nursing • Routine eye care (Adult) (subject to various limits for an eye exam and lenses per person per calendar year for individuals age 19 and over; up to $70 per person per calendar year for frames)

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: the Department of Labor's Employee Benefits Security Administration at 1-866-444-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 on how 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 at (952) 851-5797 or 1-844-468-5917. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-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:

Spanish (Español): Para obtener asistencia en Español, llame al (952) 851-5797 or 1-844-468-5917

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** **$750**
- **Specialist copayment and coinsurance** **$50, then 20%**
- **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	$750
Copayments	$50
Coinsurance	$2,210
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$3,030**

Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** **$750**
- **Specialist copayment and coinsurance** **$50, then 20%**
- **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	$750
Copayments	$180
Coinsurance	$890
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,820**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$750**
- **Specialist copayment and coinsurance** **$50, then 20%**
- **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	$750
Copayments	$440
Coinsurance	$320
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,510**

*** NOTE:** These numbers assume the patient does not participate in the Plan's Healthy Start Prenatal Support (wellness) program. If the patient participates in the wellness program, the patient may be able to reduce her cost. For more information about the wellness program, please contact: the Plan at (952) 851-5797 or 1-844-468-5917.

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