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 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms used in this SBC, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150 to $2,000** per person (depending on the deductible chosen) **$450 to $6,000** per family (3 times the individual deductible)	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Your deductible does not apply to prescription coverage, preventive care services, or office copayments for in-network providers. You may elect the individual deductible rate at the initial date of coverage, and then again before the start of each calendar year. Any expenses applied against the deductible in the last three months of a calendar year will also be applied against your deductible for the next calendar year.
Are there services covered before you meet your deductible?	Yes. Preventive Care 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. For example, this plan covers certain preventive care services without cost sharing and before you meet your deductible. See a list of covered preventive care 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?	**$2,000** per person/**$6,000** per family after the deductible	The out-of-pocket limit is the most you could pay during a coverage period for your share of the cost of covered services. Your deductible is not included in the out-of-pocket limit.
What is not included in the out-of-pocket limit?	Deductibles, balance-billed 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. For a list of network providers, visit: www.healthpartners.com/openaccess	This plan uses a provider network. You will pay less if you use a provider in the plan's network for covered services. You will pay more if you use an out-of-network provider. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services.
Do you need a referral to see a specialist?	**No.** You don't need a referral to see a specialist.	You can see the specialist you choose without permission from the plan.

For more information about limitations and exceptions, see the plan document at www.ptsmn.org or call 1-800-515-2818 to request a copy.

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/visit	20% coinsurance	Deductibles and copayments do not apply for office visits at a Pipe Trades Services MN Family Health and Wellness Center. CVS Minute Clinics covered at 100%, deductible does not apply.
	Specialist visit	$25/visit	20% coinsurance	None
	Preventive care/screening/ immunization	$0	20% coinsurance	The 20% coinsurance for preventive care servicesfrom an Out-of-Network Provider does not apply if such services cannot be obtained from a Network Provider.
If you have a test	Diagnostic test (e.g., x-ray, blood work)	10% coinsurance	20% coinsurance	None
	Imaging (e.g., CT/PET scans, MRIs)	10% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at 651-645-4540	Generic drugs	20% coinsurance	Not covered (you pay 100% of the cost)	The 20% coinsurance does not apply to generic prescription drugs dispensed by a physician at a Pipe Trades Services MN Family Health & Wellness Center at the time of the office visit.
	Preferred brand drugs	20% coinsurance		
	Non-preferred brand drugs	20% coinsurance		
	Specialty drugs	20% coinsurance	Not covered (you pay 100% of the cost)	Specialty drugs are covered only if obtained from Diplomat Specialty Pharmacy (877-977-9118).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	20% coinsurance	None
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$25/visit	20% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	20% coinsurance	Coverage for room and board is limited to a semi-private room rate.

For more information about limitations and exceptions, see the plan document at www.ptsmn.org or call 1-800-515-2818 to request a copy.

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)	
	Physician/surgeon fees	10% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% coinsurance	20% coinsurance	None
	Inpatient services	10% coinsurance	20% coinsurance	None
If you are pregnant	Office visits	$25/visit	20% coinsurance	Cost sharing does not apply to some prenatal services.
	Childbirth/delivery professional services	10% coinsurance	20% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	20% coinsurance	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	20% coinsurance	None
	Rehabilitation services	10% coinsurance	20% coinsurance	None
	Habilitation services	10% coinsurance	20% coinsurance	None
	Skilled nursing care	10% coinsurance	20% coinsurance	Prior Authorization is required. Coverage for services provided at a skilled nursing facility is limited to sixty (60) days.
	Durable medical equipment	10% coinsurance	20% coinsurance	None
	Hospice services	10% coinsurance	20% coinsurance	None
If your child needs dental or eye care	Children's eye exam	$0	No charge up to $250 combined benefit per family for exam, glasses and contacts	For services from Out-of-Network Providers, the plan covers up to $250 once every calendar year towards eye exam, glasses and contact lens for participants, spouses and dependent children.
	Children's glasses	No charge for lenses. No charge up to $175 for frames.	No charge up to $250 combined benefit per family for exam, glasses and contacts	For services from Out-of-Network Providers, the plan covers up to $250 once every calendar year towards eye exam, glasses and contact lens for participants, spouses and dependent children. For services from Network Providers, the plan offers a $175 allowance towards contact lens fitting and materials in lieu of glasses.
	Children's dental check-up	$0	$0	Two exams per year

For more information about limitations and exceptions, see the plan document at www.ptsmn.org or call 1-800-515-2818 to request a copy.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (This isn't a complete list. Please see your plan document for more information and a complete list of excluded services.)

- Bariatric surgery
- Cosmetic surgery
- Gender-reassignment surgery
- Long-term care
- Routine foot care
- Massage therapy
- Treatment of learning disabilities
- Non-durable medical equipment

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document for more information and a complete list of services to which limitations may apply.)

- Acupuncture
- Hearing Aids
- Health Club Reimbursement
- Chiropractic care
- Smoking Cessation

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: Your plan at:1-800-883-2177 or 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 document also provides 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:Your plan at:1-800-883-2177, or 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.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet 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 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

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	**$1500**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$12,840**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$50
Coinsurance	$1,123
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,733**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$1500**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$7,460**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$250
Coinsurance	$565
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,375**

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

The plan's overall deductible	**$1500**
Specialist copay	**$25**
Hospital (facility) coinsurance	**10%**
Other coinsurance	**10%**

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	**$2,010**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$50
Coinsurance	$46
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,596**

*This plan's overall deductible is $150 to $2,000 per person (depending on the deductible chosen). These coverage examples use $1,500 as the overall deductible amount because that is the default deductible. The amounts paid would be different if you choose a different deductible.