




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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	\$3,500 per individual	You must pay all the costs up to the <u>deductible</u> amount before this plan begins to pay for covered services you use. Your <u>deductible</u> does not apply to prescription coverage, <u>preventive care</u> services, or office <u>copayments</u> for in-network providers. Any expenses applied against the <u>deductible</u> in the last three months of a calendar year will also be applied against your <u>deductible</u> for the next calendar year.
<b>Are there services covered before you meet your <u>deductible</u>?</b>	Yes. <u>Preventive Care</u> services are covered before you meet your <u>deductible</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive care</u> services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive care</u> services at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	\$2,850 per individual	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> .
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<u>Deductibles</u> , balance-billed charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. For a list of <u>network providers</u> , visit: <a href="http://www.healthpartners.com/openaccess">www.healthpartners.com/openaccess</a>	This <u>plan</u> uses a provider network. You will pay less if you use a <u>provider</u> in the <u>plan's</u> network for covered services. You will pay more if you use an <u>out-of-network provider</u> . Be aware, your in-network doctor or hospital may use an <u>out-of-network provider</u> for some services.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	<b>No.</b> You don't need a <u>referral</u> to see a <u>specialist</u> .	You can see the <u>specialist</u> you choose without permission from the <u>plan</u> .

For more information about limitations and exceptions, see the plan document at [www.ptsmn.org](http://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)	
<b>If you visit a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness	\$25/visit	20% <u>coinsurance</u>	<u>Deductibles</u> and <u>copayments</u> 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.
	<u>Specialist</u> visit	\$25/visit	20% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	\$0	20% <u>coinsurance</u>	The 20% <u>coinsurance</u> for <u>preventive care</u> services from an <u>Out-of-Network Provider</u> does not apply if such services cannot be obtained from a <u>Network Provider</u> .
<b>If you have a test</b>	<u>Diagnostic test</u> (e.g., x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (e.g., CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you need drugs to treat your illness or condition</b> More information about <u>prescription drug coverage</u> is available at <a href="tel:651-645-4540">651-645-4540</a>	Generic drugs	30% <u>coinsurance</u>	Not covered (you pay 100% of the cost)	The 30% <u>coinsurance</u> 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	30% <u>coinsurance</u>		
	Non-preferred brand drugs	30% <u>coinsurance</u>	Not covered (you pay 100% of the cost)	<u>Specialty drugs</u> are covered only if obtained from Diplomat Specialty Pharmacy (877-977-9118).
	<u>Specialty drugs</u>	30% <u>coinsurance</u>		
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you need immediate medical attention</b>	<u>Emergency room care</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	<u>Urgent care</u>	\$25/visit	20% <u>coinsurance</u>	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	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](http://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% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you need mental health, behavioral health, or substance use disorder services</b>	Outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you are pregnant</b>	Office visits	\$25/visit	20% <u>coinsurance</u>	<u>Cost sharing</u> does not apply to some prenatal services.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Childbirth/delivery facility services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Rehabilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Habilitation services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Prior Authorization is required. Coverage for services provided at a skilled nursing facility is limited to sixty (60) days.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	<u>Hospice services</u>	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
<b>If your child needs dental or eye care</b>	Children's eye exam	Not covered (you will pay 100% of the cost)	Not covered (you will pay 100% of the cost)	No dependent coverage
	Children's glasses	Not covered (you will pay 100% of the cost)	Not covered (you will pay 100% of the cost)	No dependent coverage
	Children's dental check-up	Not covered (you will pay 100% of the cost)	Not covered (you will pay 100% of the cost)	No dependent coverage

**Excluded Services & Other Covered Services:**

<b>Services Your <u>Plan</u> 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.)</b>		
• Bariatric surgery	• Cosmetic surgery	• Gender-reassignment surgery
• Long-term care	• Routine foot care	• Massage therapy
• Treatment of learning disabilities	• Non-durable medical equipment	

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

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

**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](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 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](http://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, kwijigo 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 <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copay</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$12,840</b>
---------------------------	-----------------

#### In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$3,500
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$1,250
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$4,860</b>

### Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copay</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$7,460</b>
---------------------------	----------------

#### In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,680
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$1,460
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Joe would pay is</b>	<b>\$3,450</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$3,500
■ <u>Specialist copay</u>	\$25
■ <u>Hospital (facility) coinsurance</u>	10%
■ <u>Other coinsurance</u>	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*)

<b>Total Example Cost</b>	<b>\$2,010</b>
---------------------------	----------------

#### In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,470
<u>Copayments</u>	\$50
<u>Coinsurance</u>	\$160
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,680</b>