




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, 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 deductible?</b>	<b>\$2,250</b> per person <b>\$6,750</b> per family (3 times the individual deductible)	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 services</u> , 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 deductible?</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 preventive care 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 deductibles for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	<b>\$2,000</b> per person/ <b>\$6,000</b> per family after the <u>deductible</u>	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. Payments you make toward a deductible and any other payments expressly identified by a Plan do not apply toward your out-of-pocket limit. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
<b>What is not included in the out-of-pocket limit?</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 network provider?</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 referral to see a specialist?</b>	No. 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)	
If you visit a health care provider's office or clinic	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 & Wellness Center (operated by Premise Health). CVS Minute Clinics covered at 100%, <u>deductible</u> does not apply.
	<u>Specialist</u> visit	\$25/visit	20% <u>coinsurance</u>	
	<u>Preventive care/screening/immunization</u>	\$0	20% <u>coinsurance</u>	
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at 866-328-2005 (Optum Member HelpDesk)	Generic drugs	20% <u>coinsurance</u>	Not covered (you pay 100% of the cost)	The 20% <u>coinsurance</u> does not apply to generic prescription drugs dispensed by a provider at a Pipe Trades Services MN Family Health & Wellness Center (operated by Premise Health) at the time of the office visit.
	Preferred brand drugs	20% <u>coinsurance</u>		
	Non-preferred brand drugs	20% <u>coinsurance</u>	Not covered (you pay 100% of the cost)	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>		
If you have outpatient surgery	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
If you need immediate medical attention	<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
If you have a hospital stay	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.

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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
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	Certain outpatient services are available at the Pipe Trades Services MN Family Health & Wellness Center (operated by Premise Health) ( <u>deductibles</u> and <u>copayments</u> do not apply at the Wellness Centers)
	Inpatient services	10% <u>coinsurance</u>	20% <u>coinsurance</u>	None
If you are pregnant	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
If you need help recovering or have other special health needs	<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
If your child needs dental or eye care	Children's eye exam	\$0	No charge up to \$250 combined benefit per person for exam, glasses and contacts <u>Support Workers</u> : 20% <u>coinsurance</u>	For services from <u>Out-of-Network Providers</u> , the plan covers up to \$250 once every calendar year towards eye exam, glasses and contact lens for participants, spouses and dependent children. <u>Support Workers</u> : Comments do not apply.
	Children's glasses	No charge for lenses. No charge up to \$175 for frames. <u>Support Workers</u> : Not covered	No charge up to \$250 combined benefit per person for exam, glasses and contacts <u>Support Workers</u> : Not covered	For services from <u>Out-of-Network Providers</u> , 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 <u>Network Providers</u> , the plan offers a \$175 allowance

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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)	
				towards contact lens fitting and materials in lieu of glasses. <u>Support Workers:</u> Comments do not apply.
	Children's dental check-up	\$0 <u>Support Workers:</u> Not covered	\$0 <u>Support Workers:</u> Not covered	Two exams per year <u>Support Workers:</u> Comments do not apply.

### 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.)

- Bariatric surgery
- Long-term care
- Cosmetic surgery
- Routine foot care
- Massage therapy
- Non-durable medical equipment

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

- Acupuncture
- Chiropractic care
- Hearing Aids
- 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: the Minnesota Department of Health at 1-877-676-5414 or [www.health.state.mn.us](http://www.health.state.mn.us) 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 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: 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.**

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 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, kwijijgo 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>	\$2,250
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>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>\$12,700</b>
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,250
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,120</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>	\$2,250
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>coinsurance</u>	10%
■ Prescription Drugs	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)  
Diagnostic tests (*blood work*)  
Prescription drugs (\$2,900)  
Durable medical equipment (*syringes/lancets \$500*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$900
<u>Copayments</u>	\$200
<u>Coinsurance</u>	\$680
<i>What isn't covered</i>	
Limits or exclusions	\$100
<b>The total Joe would pay is</b>	<b>\$1,880</b>

### Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$2,250
■ <u>Specialist</u> copay	\$25
■ Hospital (facility) <u>coinsurance</u>	10%
■ Other <u>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>\$2,800</b>
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$2,250
<u>Copayments</u>	\$25
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Mia would pay is</b>	<b>\$2,385</b>

The plan would be responsible for the other costs of these example covered services, in accordance with plan documents and applicable deductibles, copays, and coinsurance.