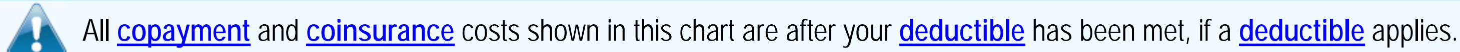
The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.
This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.ptsmn.org, or call the Fund Office at 651-645-4540 or 1-800-515-2818. 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.ptmn.org or call 651-645-4540 or 1-800-515-2818 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$150** to **$3,500** per person (depending on the deductible chosen) **$450** to **$10,500** 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, or office co-payments for services from 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 have not yet met the deductible amount. 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?	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	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.



Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay less)	Out-of-Network Provider (You will pay more)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25/visit	20% co-insurance	Deductibles and copayments do not apply for office visits at a Pipe Trades Services MN Health and Wellness Center.
	Specialist visit	$25/visit	20% co-insurance	None
	Preventive care/screening/ immunization	$0	20% co-insurance	The 20% co-insurance for preventive services from 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 (x-ray, blood work)	10% co-insurance	20% co-insurance	None
	Imaging (CT/PET scans, MRIs)	10% co-insurance	20% co-insurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ptsmn.org	Generic drugs	20% co-insurance	Not covered (you will pay 100% of the cost)	The 20% co-insurance does not apply to generic prescription drugs dispensed by a physician at a Pipe Trades Services Health & Wellness Center at the time of the office visit.
	Preferred brand drugs	20% co-insurance	Not covered (you will pay 100% of the cost)	None
	Non-preferred brand drugs	20% co-insurance	Not covered (you will pay 100% of the cost)	None
	Specialty drugs	20% co-insurance	Not covered (you will 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% co-insurance	20% co-insurance	None
	Physician/surgeon fees	10% co-insurance	20% co-insurance	None
If you need immediate medical attention	Emergency room care	10% co-insurance	10% co-insurance	None
	Emergency medical transportation	10% co-insurance	10% co-insurance	None
	Urgent care	$25/visit	20% co-insurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	10% co-insurance	20% co-insurance	Coverage for room and board is limited to a semi-private room rate.
	Physician/surgeon fees	10% co-insurance	20% co-insurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay less)	Out-of-Network Provider (You will pay more)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% co-insurance	20% co-insurance	None
	Inpatient services	10% co-insurance	20% co-insurance	None
If you are pregnant	Office visits	$25/visit	20% co-insurance	Cost sharing does not apply to some prenatal services.
	Childbirth/delivery professional services	10% co-insurance	20% co-insurance	None
	Childbirth/delivery facility services	10% co-insurance	20% co-insurance	None
If you need help recovering or have other special health needs	Home health care	10% co-insurance	20% co-insurance	None
	Rehabilitation services	10% co-insurance	20% co-insurance	A lifetime maximum of 120 visits apply for both rehabilitation and habilitation services.
	Habilitation services	10% co-insurance	20% co-insurance	A lifetime maximum of 120 visits apply for both rehabilitation and habilitation services.
	Skilled nursing care	10% co-insurance	20% co-insurance	Prior Authorization is required. Coverage for services provided at a skilled nursing facility is limited to sixty (60) days.
	Durable medical equipment	10% co-insurance	20% co-insurance	None
	Hospice services	10% co-insurance	20% co-insurance	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

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 • Treatment of learning disabilities	• Cosmetic surgery • Routine foot care • Non-durable medical equipment	• Sex-reassignment surgery • Massage therapy

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Organ Transplants • Chiropractic Services	• Acupuncture • Smoking Cessation	• Hearing Aids

Your Rights to Continue Coverage: For more information on your rights to continue coverage, contact the Fund Office at 1-800-515-2818. The contact information for the U.S. Department of Labor, Employee Benefits Security Administration is 1-866-444-EBSA or www.dol.gov/ebsa. 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 1-800-515-2818 or the U.S. Department of Labor, Employee Benefits Security Administration is 1-866-444-EBSA or www.dol.gov/ebsa.

Does this plan provide Minimum Essential Coverage? Yes.

This coverage constitutes minimum essential coverage under the Affordable Care Act, so enrolling in this coverage satisfies your obligations under the individual responsibility requirement.

Does this plan meet the Minimum Value Standards? Yes.

This plan provides a level of benefits specified in the Affordable Care Act as "minimum value."

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-929-8007.

––––––––––––––––––––––*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 deductible you elected, 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 and an election of a $150 deductible for individual coverage.**

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible — $150
- Specialist *[cost sharing]* — $25
- Hospital (facility) *[cost sharing]* — 10%
- Other *[cost sharing]* — 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	$150
Copayments	$50
Coinsurance	$1,250
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,510**

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

- The plan's overall deductible — $150
- Specialist *[cost sharing]* — $25
- Hospital (facility) *[cost sharing]* — 10%
- Other *[cost sharing]* — 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	$150
Copayments	$250
Coinsurance	$1,040
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,500**

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

- The plan's overall deductible — $150
- Specialist *[cost sharing]* — $25
- Hospital (facility) *[cost sharing]* — 10%
- Other *[cost sharing]* — 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	$150
Copayments	$80
Coinsurance	$160
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$390**

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