Pipe Trades Services MN: $150-$3500 Deductible Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family| **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ptsmn.org or by calling 651-645-4540 or 1-800-515-2818.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$150** to **$3,500** per person (depending on deductible chosen) **$450** to **$10,500** per family (3 times the individual deductible)	Members elect the individual deductible rate before the start of each calendar year or at the initial date of coverage. Deductible does not apply to prescription coverage, preventive care or co-pay services from in-network providers. You must pay all the costs up to the deductible before this plan begins to pay for other covered services. See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for the other costs for services in this plan.
Is there an out–of–pocket limit on my expenses?	**Yes. $2,000** per person, after the deductible **$6,000** per family, after the deductible	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. Remember this is on covered services after the deductible has been met.
What is not included in the out–of–pocket limit?	Premiums, 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.**
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services.
Does this plan use a network of providers?	**Yes.** For a list of Labor Care providers see www.laborcareonline.com	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I 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 this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $25) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$25 copay/visit	20% Coinsurance	-----------none-----------
	Specialist visit	$25 copay/visit	20% Coinsurance	-----------none-----------
	Other practitioner office visit	20% Coinsurance	20% Coinsurance	Limited to $40/day for chiropractic up $1100 annual benefit max. per person
	Preventive care/screening/immunization	No charge	20% Coinsurance	-----------none-----------
If you have a test	Diagnostic test (x-ray, blood work)	10% Coinsurance	20% Coinsurance	-----------none-----------
	Imaging (CT/PET scans, MRIs)	10% Coinsurance	20% Coinsurance	In Network provider CDI is covered at 100%
If you need drugs to treat your illness or condition	Generic drugs	20% Coinsurance	Not Covered	-----------none-----------
	Preferred brand drugs	20% Coinsurance	Not Covered	-----------none-----------
	Non-preferred brand drugs	20% Coinsurance	Not Covered	-----------none-----------
	Specialty drugs	20% Coinsurance	Not Covered	-----------none-----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
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 services	10% Coinsurance	10% Coinsurance	-----------none-----------
	Emergency medical transportation	10% Coinsurance	20% Coinsurance	-----------none-----------
	Urgent care	10% Coinsurance/ $25 Copay	20% Coinsurance	-----------none-----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% Coinsurance	20% Coinsurance	-----------none-----------
	Physician/surgeon fee	10% Coinsurance	20% Coinsurance	-----------none-----------
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	10% Coinsurance	20% Coinsurance	Marital therapy requires referral from EAP. Six session lifetime limit.
	Mental/Behavioral health inpatient services	10% Coinsurance	20% Coinsurance	No coverage for education or recreational services. Occupational services will be reviewed for coverage
	Substance use disorder outpatient services	10% Coinsurance	20% Coinsurance	No coverage for education or recreational services. Occupational services will be reviewed for coverage
	Substance use disorder inpatient services	10% Coinsurance	20% Coinsurance	No coverage for education or recreational services. Occupational services will be reviewed for coverage
If you are pregnant	Prenatal and postnatal care	No charge/10% Coinsurance	20% Coinsurance	Cost sharing does not apply to certain preventive services.
	Delivery and all inpatient services	10% Coinsurance	20% Coinsurance	-----------none-----------

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	10% Coinsurance	20% Coinsurance	Preauthorization is required.
	Rehabilitation services	10% Coinsurance	20% Coinsurance	$2000 maximum benefit per condition then reviewed for medical necessity
	Habilitation services	10% Coinsurance	20% Coinsurance	Lifetime maximum of 120 visits for PT, OT, SLP for developmental disorders Preauthorization is required.
	Skilled nursing care	10% Coinsurance	20% Coinsurance	Preauthorization is required.
	Durable medical equipment	10% Coinsurance	20% Coinsurance	$2000 annual maximum applies to some DME. Contact fund office
	Hospice service	10% Coinsurance	20% Coinsurance	Preauthorization is required.
If your child needs dental or eye care	Eye exam	No charge	No Charge up **to** $250 annual combined benefit for exam, glasses and contacts	——————none——————
	Glasses	Amount charged over $175 allowance for frames or contacts; No Charge for standard lenses in glasses	No Charge up **to** $250 annual combined benefit for exam, glasses and contacts	——————none——————
	Dental check-up	No charge	No charge	Two exams per year

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Bariatric surgery
- Non-durable medical equipment
- Cosmetic Surgery
- Treatment of learning disabilities
- Long-term care
- Treatment from massage therapist

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State Laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly highter than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-515-2819. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the Pipe Trade Services at 651-645-4540 or 1-800-515-2818 to request an appeal form.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

———————————————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*———————————————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $ 6,520.00
- **Patient pays** $ 1020.00

Sample care costs:

Sample care costs	
Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Patient pays	
Deductibles	$300
Copays	$0
Coinsurance	$720
Limits or exclusions	$0
Total	**$1020.00**

Based on an election of $150 deductible per person

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $ 4500.00
- **Patient pays** $ 900.00

Sample care costs:

Sample care costs	
Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Patient pays	
Deductibles	$150
Copays	$25
Coinsurance	$725
Limits or exclusions	$0
Total	**$900**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**.