

Operating Engineers: Allina PPO Plan

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

Coverage Beginning: 01/01/2017

Coverage for: Members & Dependents | 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 plan document at <https://www.healthplansinc.com/members/Benefits.aspx> or by calling 1-800-532-7575.


| Important Questions | Answers | Why this Matters: |
|---|---|--|
| What is the overall deductible ? | In-network: \$250 person/\$500 family Out-of-network: \$500 person/\$1000 family | You generally must pay all the costs up to your share of the deductible before this plan begins to pay for covered services you use. Your deductible starts over January 1 st . See the chart starting on p.2 for your costs 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 p.2 for other costs for services this plan covers. |
| Is there an out-of-pocket limit on my expenses? | Medical out-of-pocket limit: In-network: \$2500 person/\$5000 family Out-of-network: \$2500 person/\$5000 family Prescription drug out-of-pocket limit: \$3500 person/\$7000 family | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the costs of covered services. |
| What is not included in the out-of-pocket limit ? | Precertification penalties, premiums, balance-billed charges and health care this plan doesn't cover. | Even though you pay these expenses, they do not count toward the out-of-pocket limit . |
| Is there an overall annual limit on what the plan pays? | No. | The chart starting on p.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 in-network providers, visit https://www.healthplansinc.com/members/Benefits.aspx | If you use network health care providers , this plan will pay more of the costs of covered services. See the chart starting on p. 2 for how this plan pays different kinds of providers . |
| Do I need a referral to see a specialist ? | No. | 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 shown on the following pages. See your plan document for additional information about excluded services . |

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Copayments are fixed dollar amounts (for example, \$15) 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 **preferred 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 | \$15 copay | Deductible then 20% coinsurance | None |
| | Specialist visit | \$15 copay | Deductible then 20% coinsurance | None |
| | Other practitioner office visit: Acupuncture Chiropractor | Not covered \$15 copay | Not covered \$15 copay | n/a Up to 10 visits/yr |
| | Preventive care Screening—Mammogram Colonoscopy Immunization | No charge | Deductible then 20% coinsurance | See your plan document for age or frequency limits |
| If you have a test | Diagnostic test (x-ray, blood work) | Deductible | Deductible then 20% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | Deductible | Deductible then 20% coinsurance | None |

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| 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 drugs to treat your illness or condition - More information about prescription drug coverage is available at https://www.healthplansinc.com/members/Benefits.aspx . | Generic drugs: | Retail Mail Order | \$15 copay \$30 copay | Not covered | |
| | Preferred brand drugs: | Retail Mail Order | \$30 copay \$60 copay | Not covered | |
| | Non-preferred brand drugs: | Retail Mail Order | \$60 copay \$90 copay | Not covered | |
| | Specialty drugs: Purchased from pharmacy— | Retail Mail Order Provided in Physician's office Provided in Hospital | \$60 copay \$90 copay \$15 copay Deductible | Not covered Not covered Deductible then 20% coinsurance Deductible then 20% coinsurance | Covers up to a 34-day supply (retail); 34-90 day supply (mail order) None |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | | Deductible | Deductible then 20% coinsurance | None |
| | Physician/surgeon fees | | Deductible | Deductible then 20% coinsurance | None |
| If you need immediate medical attention | Emergency room services | | \$100 copay | \$100 copay | Copay is waived if admitted to hospital or for life-threatening condition |
| | Emergency medical transportation | | Deductible | In-Network Deductible | See your plan document for details. |
| | Urgent care | | \$15 copay | Deductible then 20% coinsurance | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | | Deductible | Deductible then 20% coinsurance | Call 1-866-325-1550 for precertification or you pay 20% more |
| | Physician/surgeon fee | | Deductible | Deductible then 20% coinsurance | |

 HealthPlans, Inc. **Questions:** Call 1-800-532-7575.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-532-7575 to request a copy.

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|---|--|---|---|---|
| If you have mental health, behavioral health, or substance abuse needs | Mental/Behavioral health outpatient services | No charge | Deductible then 20% coinsurance | For out-of-network providers call 1-800-878-2004 for precertification in order to receive the in-network level of benefits |
| | Mental/Behavioral health inpatient services | Deductible | Deductible then 20% coinsurance | Call 1-800-878-2004 for precertification or you pay 20% more |
| | Substance use disorder outpatient services | No charge | Deductible then 20% coinsurance | For out-of-network providers call 1-800-878-2004 for precertification in order to receive the in-network level of benefits |
| | Substance use disorder inpatient services | Deductible | Deductible then 20% coinsurance | Call 1-800-878-2004 for precertification or you pay 20% more |
| If you are pregnant | Prenatal care | \$15 copay for initial visit only | Deductible then 20% coinsurance | None |
| | Postnatal care | \$15 copay | Deductible then 20% coinsurance | None |
| | Delivery and all inpatient services | Deductible | Deductible then 20% coinsurance | Call 1-866-325-1550 for precertification for stays in excess of 48 hrs (normal delivery)/96 hrs (caesarean) or you pay 20% more |

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| 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 | Deductible | Deductible then 20% coinsurance | Up to lesser of 100 visits or 200 hours/yr. Precertification recommended--call 1-866-325-1550 |
| | Inpatient: Rehabilitation services | Deductible | Deductible then 20% coinsurance | Up to 90 days/yr combined with Skilled nursing care; call 1-866-325-1550 for precertification or you pay 20% more |
| | Outpatient: Occupational therapy Physical therapy Speech therapy | \$15 copay | Deductible then 20% coinsurance | None |
| | Habilitation services: Early intervention Developmental delay | \$15 copay Deductible | Deductible then 20% coinsurance | None Precertification recommended for treatment--call 1-866-325-1550 |
| | Skilled nursing care | Deductible | Deductible then 20% coinsurance | Up to 90 days/yr combined with Inpatient rehabilitation; call 1-866-325-1550 for precertification or you pay 20% more |
| | Durable medical equipment | Deductible | Deductible then 20% coinsurance | Precertification recommended for equipment rental over 3 months, TENS units and equipment exceeding \$1000--call 1-866-325-1550 |
| | Hospice service Inpatient Outpatient | No charge | Deductible then 20% coinsurance | Precertification recommended--call 1-866-325-1550 |
| If your child needs dental or eye care | Eye exam | No charge | No charge | Up to 1 exam/yr |
| | Glasses | Not covered | Not covered | n/a |
| | Dental check-up | Not covered | Not covered | n/a |

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Excluded Services & Other Covered Services:

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

- Acupuncture
- Eyeglasses (child & adult)
- Long-term care
- Cosmetic surgery
- Hearing aids
- Non-emergency care outside the U.S.
- Dental care (routine child & adult)
- Infertility treatment
- Weight loss programs.

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

- Bariatric surgery (to treat morbid obesity)*
- Routine eye care (adult-up to 1 exam/yr)
- Chiropractic care (up to 10 visits/yr)
- Private duty nursing

*Call 1-866-325-1550 for precertification

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 higher 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 1-800-532-7575. 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 plan at 1-800-532-7575. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

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

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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.**

Language Access Services:

Para obtener asistencia en Español, llame al 1-800-532-7575. Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-532-7575.

如果需要中文的帮助，请拨打这个号码1-800-532-7575. Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 1-800-532-7575.

*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: \$7540**
- **Plan pays \$7,120**
- **Patient pays \$420**

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:

| | |
|----------------------|--------------|
| Deductibles | \$250 |
| Copays | \$20 |
| Coinsurance | \$0 |
| Limits or exclusions | \$150 |
| Total | \$420 |

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

- **Amount owed to providers: \$5,400**
- **Plan pays \$4,380**
- **Patient pays \$1,020**

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:

| | |
|----------------------|----------------|
| Deductibles | \$250 |
| Copays | \$690 |
| Coinsurance | \$0 |
| Limits or exclusions | \$80 |
| Total | \$1,020 |

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**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.