
 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. 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 or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	In-network: \$2,000 Individual, \$6,000 Family Out-of-network: \$7,500 Individual, \$22,500 Family	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Services marked with * and benefits with no charge in Common Medical Events are not subject to <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 preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	In-network: \$4,750 Individual, \$9,500 Family Out-of-network: \$15,000 Individual, \$30,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), 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> .
Will you pay less if you use a <u>network provider</u>?	Yes. See https://www.healthpartners.com/networks or call 1-800-883-2177 for a list of <u>in-network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	Office Visit: 25% <u>coinsurance</u> Convenience Care: 25% <u>coinsurance</u> virtuwell: No charge for the first three visits and 25% <u>coinsurance</u> thereafter	Office Visit: 50% <u>coinsurance</u> Convenience Care: 50% <u>coinsurance</u> virtuwell: Not covered	None
	Specialist visit	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Preventive care/screening/immunization	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	25% <u>coinsurance</u>	50% <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 www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: \$12 <u>copay</u> * at retail, \$24 <u>copay</u> * at mail Non-formulary: \$90 <u>copay</u> * at retail, \$180 <u>copay</u> * at mail	50% <u>coinsurance</u> at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	\$45 <u>copay</u> * at retail, \$90 <u>copay</u> * at mail		
	Non-formulary brand drugs	\$90 <u>copay</u> * at retail, \$180 <u>copay</u> * at mail		
	Specialty drugs	20% <u>coinsurance</u> *	50% <u>coinsurance</u> at retail, mail not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None
	Emergency medical	25% <u>coinsurance</u>	25% <u>coinsurance</u>	None

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)	
	transportation			
	Urgent care	25% coinsurance	25% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	25% coinsurance	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	25% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	25% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	25% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	25% coinsurance	50% coinsurance	120 day maximum
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
If your child needs dental or eye care	Hospice services	25% coinsurance	50% coinsurance	None
	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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.)

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|-----------------------|------------------------|------------------------|
| • Cosmetic surgery | • Long-term care | • Routine foot care |
| • Dental care (Adult) | • Private-duty nursing | • Weight loss programs |
| • Hearing aids | | |

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

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| • Acupuncture | • Chiropractic care | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Infertility treatment | • Routine eye care (Adult) |

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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department. 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: Your plan at: 1-800-883-2177, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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 plan's overall deductible \$2,000
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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*)

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$2,000
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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*)

Mia's Simple Fracture

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

- The plan's overall deductible \$2,000
- Specialist coinsurance 25%
- Hospital (facility) coinsurance 25%
- Other coinsurance 25%

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	\$12,700
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Total Example Cost	\$7,300
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Total Example Cost	\$1,900
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In this example, Peg would pay:

In this example, Joe would pay:

In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$40
Coinsurance	\$2,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,300

<i>Cost Sharing</i>	
Deductibles	\$2,000
Copayments	\$900
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,160

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900