
 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: \$2,500 Individual, \$7,500 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. <u>Coinsurance</u> marked with * under What You Will Pay and <u>copays</u> and benefits with no charge 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 medical/pharmacy: \$5,000 Individual, \$10,000 Family Out-of-network medical/pharmacy: \$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> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been 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 www.healthpartners.com/Achieve 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 charge</u> 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.

Important Questions	Answers	Why This Matters:
Do you need a <u>referral</u> to see a <u>specialist</u> ?	No.	You can see the in-network <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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: No charge for the first three visits and 25% <u>coinsurance</u> thereafter Convenience Care: No charge for the first three visits and 25% <u>coinsurance</u> thereafter Virtuwell: No charge	Primary Office Visit: 50% <u>coinsurance</u> Convenience Care: 50% <u>coinsurance</u>	Each family member's first 3 combined office or urgent care visits are free. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
	<u>Specialist</u> visit	No charge for the first three visits and 25% <u>coinsurance</u> thereafter	50% <u>coinsurance</u>	Each family member's first 3 combined office or urgent care visits are free. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
	<u>Preventive care/screening/immunization</u>	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	<u>Diagnostic test</u> (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

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)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html</p>	Generic drugs	<p><u>Formulary Low Cost</u>: \$5 copay at retail, \$15 copay at mail</p> <p><u>Formulary High Cost</u>: \$25 copay at retail, \$75 copay at mail</p> <p>Non-formulary: \$150 copay at retail, \$450 copay at mail</p>	<p><u>Formulary</u>: 50% coinsurance at retail, mail not covered</p> <p>Non-formulary: 50% coinsurance at retail, mail not covered</p>	<p>Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.</p>
	Formulary brand drugs	\$60 copay at retail, \$180 copay at mail	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	\$150 copay at retail, \$450 copay at mail	50% coinsurance at retail, mail not covered	
	<u>Specialty drugs</u>	25% coinsurance*	50% coinsurance at retail, mail not covered	
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
<p>If you need immediate medical attention</p>	<u>Emergency room care</u>	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	<u>Emergency medical transportation</u>	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	<u>Urgent care</u>	No charge for the first three visits and 25% coinsurance thereafter	No charge for the first three visits and 25% coinsurance thereafter	Out-of-network services apply to the in-network deductible.
<p>If you have a hospital stay</p>	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
<p>If you need mental health, behavioral health, or substance use disorder services</p>	Outpatient services	No charge for the first three visits and 25% coinsurance thereafter	50% coinsurance	Free visits do not apply to services performed in a hospital. Each family member's first 3 office or urgent care visits are free. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
	Inpatient services	25% coinsurance	50% coinsurance	None
<p>If you are pregnant</p>	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may

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)	
				apply.
	Childbirth/delivery professional services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	<u>Rehabilitation services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-network: 20 visit limit/year
	<u>Habilitation services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Out-of-network: 20 visit limit/year
	<u>Skilled nursing care</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	120 days per calendar year
	<u>Durable medical equipment</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to one wig per year for Alopecia Areata
	<u>Hospice services</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u>	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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u>.)		
<ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery Dental care (Adult) 	<ul style="list-style-type: none"> Infertility treatment Long-term care Private-duty nursing 	<ul style="list-style-type: none"> Routine foot care Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.)		
<ul style="list-style-type: none"> Acupuncture, limit of 15 visits Chiropractic care 	<ul style="list-style-type: none"> Hearing aids Non-emergency care when traveling outside the U.S. 	<ul style="list-style-type: none"> 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 MN Dept of Commerce at 651-539-1600 / 1-800-657-3602. 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 www.dol.gov/ebsa/healthreform or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602.

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, 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	\$2,500
■ Specialist coinsurance	0%
■ 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*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$10
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,470

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$2,500
■ Specialist coinsurance	0%
■ 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*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,900
Copayments	\$900
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,820

Mia's Simple Fracture

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

■ The plan's overall deductible	\$2,500
■ Specialist coinsurance	0%
■ 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	\$2,800
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,500
Copayments	\$10
Coinsurance	\$70
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,580