State of MN Minnesota Advantage Plan Cost Level 2, HealthPartners

Coverage Period: Beginning on or after 01-01-2013

Summary of Benefits and Coverage: What this Plan covers & What it Costs **Coverage for:** Single and family coverage | **Plan Type:** Tiered Network

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.healthpartners.com/segip** or by calling 952-883-7900 or toll free at 1-888-343-4404.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$140** per person In-Network **$280** per family In-Network **$350** per person Out-of-Network (only when permitted) **$700** per family Out-of-Network (only when permitted)	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). 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?	There are no other specific **deductibles**.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$1,100** medical per person all providers **$2,200** medical per family all providers **$800** prescription drugs per person **$1,600** prescription drugs per family	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.
What is not included in the out-of-pocket limit?	Premiums, balanced-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, such as office visits.
Does this plan use a network of providers?	Yes. For a list of preferred providers, see www.healthpartners.com/segip or call 952-883-7900 or toll free at 1-888-343-4404	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.**

Important Questions	Answers	Why this Matters:
Do I need a referral to see a specialist?	Yes.	The plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4 or 5. See your policy or plan document for additional information about **excluded services**.

- **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 In-Network **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.
- **Out of Network** coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and all dependent children, including college students, and spouses living out of area.
- The level of the office visit copayment for the employee and his or her family is dependent upon whether you have completed the Health Assessment in each Open Enrollment. Employees who have completed the Health Assessment and agreed to a follow-up with a Health Coach.
- **Employees who live and work out-of-area**. Employees whose Permanent Residence and principal work location are outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan may receive Cost Level 2 benefits in the area of their Permanent Residence if they obtain services from the PPO of the Claims Administrator with whom they are enrolled. If a PPO provider is not available in their area, they may receive Cost Level 2 benefits from any licensed provider in their area. If PPO provider is available but not used, coverage will be limited to the point-of-service benefits ($350/$700 deductible, 30% coinsurance).

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	$22/$27 copay/visit	30% coinsurance (if permitted)	_____none_____
	Specialist visit	$22/$27 copay/visit	30% coinsurance (if permitted)	_____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
	Other practitioner office visit	$22/$27 copay/visit for Chiropractors	30% coinsurance for Chiropractors (if permitted)	_____none_____
	Preventive care/screening/immunization	0% coinsurance	30% coinsurance (if permitted)	No deductible applies in network
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance when related to the office visit; 5% coinsurance when unrelated to the office visit	30% coinsurance (if permitted)	_____none_____
	Imaging (CT/PET scans, MRIs)	5% coinsurance	30% coinsurance (if permitted)	_____none_____
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Navitus.com.	Generic drugs	$10.00 retail $20.00 mail order	Not covered retail drugs Not covered mail order drugs	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager. Some preferred brand drugs are included in this tier. Diabetic supplies at 80%.
	Preferred brand drugs	$16.00 retail $32.00 mail order	Not covered retail drugs Not covered mail order drugs	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager. Some generic drugs are included in this tier. Diabetic supplies at 80%.
	Non-preferred brand drugs	$36.00 retail $72.00 mail order	Not covered retail drugs Not covered mail order drugs	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager. Diabetic supplies at 80%

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
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$110 copay/surgery	30% coinsurance (if permitted)	_____none_____
	Physician/surgeon fees	0% coinsurance	30% coinsurance (if permitted)	No deductible applies in network
If you need immediate medical attention	Emergency room services	$75 copay/visit	$75 copay/visit	_____none_____
	Emergency medical transportation	5% coinsurance	5% coinsurance	_____none_____
	Urgent care	$22/$27 copay/visit	$22/$27 copay/visit	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	$180 copay/admission	30% coinsurance (if permitted)	_____none_____
	Physician/surgeon fee	0% coinsurance	30% coinsurance (if permitted)	No deductible applies in network
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$22/$27 copay/visit in an office 5% coinsurance in a facility	30% coinsurance (if permitted)	_____none_____
	Mental/Behavioral health inpatient services	$180 copay/admission	30% coinsurance (if permitted)	_____none_____
	Substance use disorder outpatient services	$22/$27 copay/visit in an office 5% coinsurance in a facility	30% coinsurance (if permitted)	_____none_____
	Substance use disorder inpatient services	$180 copay/admission	30% coinsurance (if permitted)	_____none_____
If you are pregnant	Prenatal and postnatal care	0% coinsurance	30% coinsurance (if permitted)	No deductible applies in network
	Delivery and all inpatient services	$180 copay/admission	30% coinsurance (if permitted)	_____none_____
If you need help	Home health care	5% coinsurance	30% coinsurance (if permitted)	_____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
recovering or have other special health needs	Rehabilitation services Habilitation services	$22/$27 copay/visit for occupational therapy $22/$27 copay/visit for physical therapy $22/$27 copay/visit for speech therapy	30% coinsurance for occupational therapy(if permitted) 30% coinsurance for physical therapy (if permitted) 30% coinsurance for speech therapy (if permitted)	_____none_____
	Skilled nursing care	0% coinsurance	30% coinsurance (if permitted)	No deductible applies in network
	Durable medical equipment	20% coinsurance	30% coinsurance(if permitted)	No deductible applies in network
	Hospice service	0% coinsurance	30% coinsurance (if permitted)	180 day maximum applies for all networks. 2 per hospice episode maximum per lifetime for all networks. No deductible applies in network
If your child needs dental or eye care	Eye exam	0% coinsurance	30% coinsurance(if permitted)	No deductible applies in network
	Glasses	Not covered	Not covered	Services are not covered.
	Dental check-up	Not covered	Not covered	Services are not covered

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.)	**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.)**
• Cosmetic surgery • Dental Care • Infertility treatment • Long Term Care • Most non-emergency care when traveling outside the U.S. • Routine foot care • Weight loss programs	• Acupuncture (subject to coverage limitations) • Bariatric surgery • Chiropractic Care • Hearing aids • Private-duty nursing (as required by Minnesota State law) • Routine eye care (Adult)

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information, on your rights to continue coverage, contact the insurer at 952-883-7900 or toll free at 1-888-343-4404.

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 your Claims Administrator by calling 952-883-7900 or toll free at 1-888-343-4404. If you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance Assistance Team at 888-393-2789.

Language Access Services:

Chinese (中文): 如果需要中文的帮助，请拨打这个号码	1-888-343-4404
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-888-343-4404
Spanish (Español): Para obtener asistencia en Español, llame al	1-888-343-4404
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-888-343-4404

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.

The "Patient pays" amounts assume the patient is not using funds from a Flexible Spending Account (FSA), a Health Savings Account (HSA), or an integrated Health Reimbursement Arrangement (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

Having a baby
(normal delivery)

- **Amount owed to providers: $7,540**
- **Plan pays $6,990**
- **Patient pays $550**

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	$140
Copays	$200
Coinsurance	$10
Limits or exclusions	$200
Total	**$550**

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	$140
Copays	$600
Coinsurance	$200
Limits or exclusions	$80
Total	**$1020**

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.