CentraCare Health Medical Plan

Coverage Period: Beginning 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan covers & What it Costs **Coverage for:** All Coverage Levels | **Plan Type:** ACO

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/centracare** or by calling 1-844-565-0629.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,750 single/$3,500 family** In-Network Tier I & II **$2,000 single/$4,000 family** Tier III, Out-of-Network Note: These are combined deductibles and will apply to satisfy Tier III deductible Your employer HRA contribution of $1,000 (single), $2,000 (family), helps cover the cost of the deductible.	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?	No	You do not 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?	**$3,000 single/$6,000 family** In-Network Tier I & II **$4,000 single/$8,000 family** Tier III, Out-of-Network **Pharmacy:** $1,500 single/$3,000 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. **$1 million lifetime maximum for services received from out-of-network (Tier III) providers.**
What is not included in the out-of-pocket limit?	Premiums, balanced-billed charges, (unless balance billing is prohibited), 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, **CentraChoice ACO.** For a list of preferred providers, see www.healthpartners.com/centracare or call 1-844-565-0629.	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

If you are not clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call1-844-565-0629 to request a copy.

Important Questions	Answers	Why this Matters:
		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. If you choose to see a Tier II or III provider, you will be responsible for the difference in the deductible, coinsurance, and out-of-pocket maximum amounts.
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, $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 encourages you to use In-Network **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 Tier I Provider	Your cost if you use an In-Network Tier II 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	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Specialist visit	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Other practitioner office visit	Chiropractic services Tier II benefit applies	Chiropractic services 20% coinsurance after deductible	Chiropractic services 40% coinsurance after deductible	A limit of 20 visits per calendar year

Common Medical Event	Services You May Need	Your cost if you use an In-Network Tier I Provider	In-Network Tier II Provider	Out-of-Network Provider	Limitations & Exceptions
	Preventive care/screening/immunization	100% covered	100% covered	40% coinsurance after deductible	Routine hearing and vision exams covered 1 per calendar year. **$300 annual maximum for preventive services received from OON providers.**
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/centracare.	Formulary Generic drugs	$8 copay/retail	$24 copay	No Coverage	34 day supply/102 day supply retail **90 day supply of generic maintenance drugs for 2 copays ($16) at Tier I pharmacies**
	Formulary Brand drugs	$30 copay/retail	$50 copay/retail	No Coverage	34 day supply/102 day supply retail
	Non-Formulary Generic & Brand drugs	$50 copay/retail	$70 copay/retail	No Coverage	See Above
	Speciality Oral/Injectible drugs	20% coinsurance (no deductible) up to $125 max copay per prescription	30% coinsurance (no deductible) up to $125 max copay per	No Coverage	See Above
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fees	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In-Network Tier I Provider	In-Network Tier II Provider	Out-of-Network Provider	Limitations & Exceptions
If you need immediate medical attention	Emergency room services	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after in-network deductible	——————none——————
	Emergency medical transportation, (Ambulance)	20% coinsurance, (no deductible)	20% coinsurance, (no deductible)	20% coinsurance, (no deductible)	——————none——————
	Urgent care	20% coinsurance after deductible	20% coinsurance after deductible	20% coinsurance after in-network deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Physician/surgeon fee	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services, (per office visit)	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Mental/Behavioral health inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Substance use disorder outpatient services	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
	Substance use disorder inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you are pregnant	Prenatal Exams & Well-child Exams, (birth to age 6)	Covered at 100% (no deductible)	Covered at 100% (no deductible)	40% coinsurance (after deductible)	——————none——————
	Delivery and all inpatient services	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	120 visit limit
	Rehabilitation services	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	——————none——————

Common Medical Event	Services You May Need	Your cost if you use an In-Network Tier I Provider	In-Network Tier II Provider	Out-of-Network Provider	Limitations & Exceptions
	Habilitation services	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Skilled nursing care	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	————————none————————
	Durable medical equipment	20% coinsurance (no deductible)	20% coinsurance (no deductible)	20% coinsurance (no deductible)	————————none————————
	Hospice service	20% coinsurance after deductible	30% coinsurance after deductible	40% coinsurance after deductible	————————none————————
If your child needs dental or eye care	Eye exam	Covered at 100% (no deductible)	Covered at 100% (no deductible)	40% coinsurance (after deductible)	Covered once per year
	Glasses	Not covered	Not covered	Not covered	No coverage for these services
	Dental check-up	Not covered	Not covered	Not covered	No coverage for these services

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 • Long-Term Care	• Acupuncture • Weight loss programs • Non-emergency care when traveling outside of the U.S.	• Chiropractic Care • Infertility Services AI/IUI procedures : $10,000 combined Medical/RX Lifetime Maximum • Transplant Services

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 this health insurance coverage. Any such rights may be limited in duration and will require you to pay a **premium** that may be significantly higher than the premium you pay while covered under the plan as an employee. Other limitations on your rights to continue coverage may also apply.

If you are an employee of CCH covered by the group health plan, you have the right to choose this continuation of coverage if you lose your group health coverage because of a reduction in hours or termination of your employment, (for reasons other than gross misconduct on your part). There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State

Additional information on your right to continue coverage can be found in the 2016 Employee Benefits Guide or by contacting Abby Foley at (320) 251-2700 x54619.

For additional information, please contact 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 HealthPartners at 1-844-565-0629. Additional information can be found in your HealthPartners Summary Plan Description.

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.**

Does the Coverage Meet the Minimum Value Statement?

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:

Chinese (中文): 如果需要中文的帮助，请拨打这个号码	1-844-565-0629
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne'	1-844-565-0629
Spanish (Español): Para obtener asistencia en Español, llame al	1-866-398-9119
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa	1-844-565-0629

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. Cost sharing or "Patient pays" amounts are based on self-only coverage. You should consider your Health Reimbursement Account (HRA) when reviewing these Coverage Examples.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $4,632
- **Patient pays** $2,908

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: Assuming Tier I Benefits

Deductibles (Single)	$1,750
Copays	$0
Coinsurance (80/20%)	$1,158
Limits or exclusions	$0
Total	**$2,908**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,460
- **Patient pays** $1,940

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: Assuming Tier I Benefits

Deductibles (Single)	$1,100
Copays	$0
Coinsurance (80/20%)	$840
Limits or exclusions	$0
Total	**$1,940**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs do not include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and are not 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 is not 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 will 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.