MedicareRx
Prescription Drug Coverage

HealthPartners®

HealthPartners® Freedom Plans with Rx
2016 Summary of Benefits — Minnesota

(A Cost Plan offered by GROUP HEALTH PLAN, INC. (MN) with a Medicare contract)

JANUARY 1, 2016 - DECEMBER 31, 2016

HealthPartners Freedom Vital with Rx (Cost)
HealthPartners Freedom Balance with Rx (Cost)
HealthPartners Freedom Ultimate with Rx (Cost)
HealthPartners Freedom Ultimate with Enhanced Rx (Cost)

7220 MN Freedom Rx SB (8/15) ©2015 HealthPartners
H2462_90808 Accepted 8/24/2015
HealthPartners is a Cost plan with a Medicare contract. Enrollment in HealthPartners depends on contract renewal.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-247-7015. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-247-7015. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-800-247-7015。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-800-247-7015。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-247-7015. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-247-7015. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-247-7015 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-247-7015. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-247-7015 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-247-7015. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic:

إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-247-7015. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-247-7015 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-247-7015. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-247-7015. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-247-7015. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-247-7015. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-247-7015 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

H2462 H2422_69964 CMS Accepted 7/13/2013

SUMMARY OF BENEFITS
JANUARY 1, 2016 - DECEMBER 31, 2016

This booklet gives you a summary of what we cover and what you pay. It doesn't list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, call us and ask for the "Evidence of Coverage."

YOU HAVE CHOICES ABOUT HOW TO GET YOUR MEDICARE BENEFITS

• One choice is to get your Medicare benefits through Original Medicare (fee-for-service Medicare). Original Medicare is run directly by the Federal government.

• Another choice is to get your Medicare benefits by joining a Cost plan (such as HealthPartners Freedom Vital with Rx (Cost), HealthPartners Freedom Balance with Rx (Cost), HealthPartners Freedom Ultimate with Rx (Cost) or HealthPartners Freedom Ultimate with Enhanced Rx (Cost)).

TIPS FOR COMPARING YOUR MEDICARE CHOICES

This Summary of Benefits booklet gives you a summary of what HealthPartners Freedom Vital with Rx (Cost), HealthPartners Freedom Balance with Rx (Cost), HealthPartners Freedom Ultimate with Rx (Cost) and HealthPartners Freedom Ultimate with Enhanced Rx (Cost) cover and what you pay.

• If you want to compare our plan with other Medicare health plans, ask the other plans for their Summary of Benefits booklets. Or, use the Medicare Plan Finder on **medicare.gov**.

• If you want to know more about the coverage and costs of Original Medicare, look in your current **"Medicare & You"** handbook. View it online at **medicare.gov** or get a copy by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTIONS IN THIS BOOKLET

• Things to Know About HealthPartners Freedom Vital with Rx (Cost), HealthPartners Freedom Balance with Rx (Cost), HealthPartners Freedom Ultimate with Rx (Cost) and HealthPartners Freedom Ultimate with Enhanced Rx (Cost)

• Monthly Premium, Deductible, and Limits on How Much You Pay for Covered Services

• Covered Medical and Hospital Benefits

• Prescription Drug Benefits

• Optional Benefits (you must pay an extra premium for these benefits)

This document is available in other formats such as Braille and large print. This document may be available in a non-English language. For additional information, call us at **952-883-7979** or **800-233-9645**. TTY users should call **952-883-6060** or **800-443-0156**.

THINGS TO KNOW ABOUT
HEALTHPARTNERS FREEDOM VITAL WITH RX (COST), HEALTHPARTNERS FREEDOM BALANCE WITH RX (COST), HEALTHPARTNERS FREEDOM ULTIMATE WITH RX (COST) AND HEALTHPARTNERS FREEDOM ULTIMATE WITH ENHANCED RX (COST)

HOURS OF OPERATION

• From October 1 to February 14, you can call us 7 days a week from 8:00 a.m. to 8:00 p.m. Central time.

• From February 15 to September 30, you can call us Monday through Friday from 8:00 a.m. to 8:00 p.m. Central time.

HEALTHPARTNERS FREEDOM VITAL WITH RX (COST), HEALTHPARTNERS FREEDOM BALANCE WITH RX (COST), HEALTHPARTNERS FREEDOM ULTIMATE WITH RX (COST) AND HEALTHPARTNERS FREEDOM ULTIMATE WITH ENHANCED RX (COST) PHONE NUMBERS AND WEBSITE

• If you are a member of this plan, call toll-free **800-233-9645.** TTY/TDD **800-443-0156**.

• If you are not a member of this plan, call toll-free **800-247-7015.** TTY/TDD **800-443-0156**.

• Our website: **healthpartners.com/medicare**

WHO CAN JOIN?

To join HealthPartners Freedom Vital with Rx (Cost), HealthPartners Freedom Balance with Rx (Cost), HealthPartners Freedom Ultimate with Rx (Cost), or HealthPartners Freedom Ultimate with Enhanced Rx (Cost), you must be enrolled in Medicare Part B (or have both Medicare Part A and Medicare Part B) and live in our service area.

Our service area includes the following counties in Minnesota: Aitkin, Anoka, Becker, Beltrami, Benton, Big Stone, Blue Earth, Brown, Carlton, Carver, Cass, Chippewa, Chisago, Clay, Clearwater, Cook, Cottonwood, Crow Wing, Dakota, Dodge, Douglas, Faribault, Fillmore, Freeborn, Goodhue, Grant, Hennepin, Houston, Hubbard, Isanti, Itasca, Jackson, Kanabec, Kandiyohi, Kittson, Koochiching, Lac qui Parle, Lake, Lake of the Woods, Le Sueur, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Mille Lacs, Morrison, Mower, Murray, Nicollet, Nobles, Norman, Olmsted, Otter Tail, Pennington, Pine, Pipestone, Polk, Pope, Ramsey, Red Lake, Redwood, Renville, Rice, Rock, Roseau, Scott, Sherburne, Sibley, St. Louis, Stearns, Steele, Stevens, Swift, Todd, Traverse, Wabasha, Wadena, Waseca, Washington, Watonwan, Wilkin, Winona, Wright and Yellow Medicine.

WHICH DOCTORS, HOSPITALS AND PHARMACIES CAN I USE?

HealthPartners Freedom Vital with Rx (Cost), HealthPartners Freedom Balance with Rx (Cost), HealthPartners Freedom Ultimate with Rx (Cost) and HealthPartners Freedom Ultimate with Enhanced Rx (Cost) have a network of doctors, hospitals, pharmacies and other providers. If you use the providers in our network, you may pay less for your covered services. But if you want to, you can also use providers that are not in our network. You must generally use network pharmacies to fill your prescriptions for covered Part D drugs. Some of our network pharmacies have preferred cost-sharing. You may pay less if you use these pharmacies.

You can see our plans' provider directories at our website (**healthpartners.com/medicare**). You can see our plans' pharmacy directory at our website (**healthpartners.com/medicare**). Or, call us and we will send you a copy of the provider and pharmacy directories.

WHAT DO WE COVER?

Our plan members get all of the benefits covered by Original Medicare. For some of these benefits, you may pay more in our plan than you would in Original Medicare. For others, you may pay less.

We cover Part D drugs. In addition, we cover Part B drugs, such as chemotherapy and some drugs administered by your provider. You can see the complete plan formulary (list of Part D prescription drugs) and any restrictions on our website, **healthpartners.com/medicarerx.** Or, call us and we will send you a copy of the formulary.

HOW WILL I DETERMINE MY DRUG COSTS?

Our plans group each medication into one of five "tiers." You will need to use your formulary to locate what tier your drug is on to determine how much it will cost you. The amount you pay depends on the drug's tier and what stage of the benefit you have reached. Later in this document we discuss the benefit stages that occur after you meet your deductible: Initial Coverage, Coverage Gap and Catastrophic Coverage.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
How much is the monthly premium?	$63.30 per month. In addition, you must keep paying your Medicare Part B premium.	$134.20 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$195 per year for Part D prescription drugs.	$175 per year for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,400 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.

COVERED MEDICAL AND HOSPITAL BENEFITS

Note: Services with a [1] may require prior authorization.

OUTPATIENT CARE AND SERVICES		
	HealthPartners® Freedom Vital with Rx (Cost)	**HealthPartners® Freedom Balance with Rx (Cost)**
Acupuncture	$35 copay.	$15 copay.
Ambulance	20% of the cost.	10% of the cost.

MONTHLY PREMIUM, DEDUCTIBLE, AND LIMITS ON HOW MUCH YOU PAY FOR COVERED SERVICES

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
How much is the monthly premium?	$212.50 per month. In addition, you must keep paying your Medicare Part B premium.	$354.10 per month. In addition, you must keep paying your Medicare Part B premium.
How much is the deductible?	$170 per year for Part D prescription drugs.	$150 per year for Part D prescription drugs.
Is there any limit on how much I will pay for my covered services?	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,000 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.	Yes. Our plan protects you by having yearly limits on your out-of-pocket costs for medical and hospital care. Your yearly limit(s) in this plan: • $3,000 for services you receive from in-network providers. If you reach the limit on out-of-pocket costs, you keep getting covered hospital and medical services and we will pay the full cost for the rest of the year. Please note that you will still need to pay your monthly premiums and cost-sharing for your Part D prescription drugs.
Is there a limit on how much the plan will pay?	No. There are no limits on how much our plan will pay.	No. There are no limits on how much our plan will pay.

COVERED MEDICAL AND HOSPITAL BENEFITS

Note: Services with a [1] may require prior authorization.

OUTPATIENT CARE AND SERVICES		
	HealthPartners® Freedom Ultimate with Rx (Cost)	**HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)**
Acupuncture	You pay nothing	You pay nothing.
Ambulance	You pay nothing.	You pay nothing.

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $15 copay.	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): $15 copay.
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing. Preventive dental services: • Cleaning (for up to 1 every year): You pay nothing. • Dental X-ray (for up to 1 every year): You pay nothing. • Oral exam (for up to 1 every year): You pay nothing.
Diabetes Supplies and Services	Diabetes monitoring supplies: 20% of the cost. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: 20% of the cost.	Diabetes monitoring supplies: 20% of the cost. Diabetes self-management training: You pay nothing. Therapeutic shoes or inserts: 20% of the cost.
Diagnostic Tests, Lab and Radiology Services, and X-rays *(Costs for these services may vary based on place of service)*	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost. Diagnostic tests and procedures: You pay nothing. Lab services: You pay nothing. Outpatient X-rays: 10% of the cost. Therapeutic radiology services (such as radiation treatment for cancer): 10% of the cost.	Diagnostic radiology services (such as MRIs, CT scans): 20% of the cost. Diagnostic tests and procedures: You pay nothing. Lab services: You pay nothing. Outpatient X-rays: You pay nothing. Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing.
Doctor's Office Visits	Primary care physician visit: $15 copay. Specialist visit: $40 copay. Convenience clinic visits at walk-in clinics that have a contract with us: $15 copay.	Primary care physician visit: $15 copay. Specialist visit: $15 copay. Convenience clinic visits at walk-in clinics that have a contract with us: $15 copay.

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Chiropractic Care	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing.	Manipulation of the spine to correct a subluxation (when 1 or more of the bones of your spine move out of position): You pay nothing.
Dental Services	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing. Preventive dental services: • Cleaning (for up to 1 every year): You pay nothing. • Dental X-ray (for up to 1 every year): You pay nothing. • Oral exam (for up to 1 every year): You pay nothing.	Limited dental services (this does not include services in connection with care, treatment, filling, removal, or replacement of teeth): You pay nothing. Preventive dental services: • Cleaning (for up to 1 every year): You pay nothing. • Dental X-ray (for up to 1 every year): You pay nothing. • Oral exam (for up to 1 every year): You pay nothing.
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Diagnostic Tests, Lab and Radiology Services, and X-rays *(Costs for these services may vary based on place of service)*	Diagnostic radiology services (such as MRIs, CT scans): 10% of the cost. Diagnostic tests and procedures: You pay nothing. Lab services: You pay nothing. Outpatient X-rays: You pay nothing. Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing.	Diagnostic radiology services (such as MRIs, CT scans): 10% of the cost. Diagnostic tests and procedures: You pay nothing. Lab services: You pay nothing. Outpatient X-rays: You pay nothing. Therapeutic radiology services (such as radiation treatment for cancer): You pay nothing.
Doctor's Office Visits	Primary care physician visit: You pay nothing. Specialist visit: You pay nothing. Convenience clinic visits at walk-in clinics that have a contract with us: You pay nothing.	Primary care physician visit: You pay nothing. Specialist visit: You pay nothing. Convenience clinic visits at walk-in clinics that have a contract with us: You pay nothing.

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% of the cost.	20% of the cost.
Emergency Care	$75 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Emergency care outside the U.S.: 20% of the cost.	$65 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Emergency care outside the U.S.: 20% of the cost.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $40 copay.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: $15 copay.
Hearing Services	Exam to diagnose and treat hearing and balance issues: $40 copay. Routine hearing exam (for up to 1 every year): You pay nothing.	Exam to diagnose and treat hearing and balance issues: $15 copay. Routine hearing exam (for up to 1 every year): You pay nothing.
Home Health Care	You pay nothing.	You pay nothing.
Mental Health Care	Inpatient visit: The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $400 copay per stay. • You pay nothing per day for days 91 and beyond. Outpatient group therapy visit: $20 copay. Outpatient individual therapy visit: $40 copay.	Inpatient visit: The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $200 copay per stay. • You pay nothing per day for days 91 and beyond. Outpatient group therapy visit: $7.50 copay. Outpatient individual therapy visit: $15 copay.

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Durable Medical Equipment *(wheelchairs, oxygen, etc.)*	20% of the cost.	20% of the cost.
Emergency Care	$50 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Emergency care outside the U.S.: 20% of the cost.	$50 copay. If you are admitted to the hospital within 24 hours, you do not have to pay your share of the cost for emergency care. See the "Inpatient Hospital Care" section of this booklet for other costs. Emergency care outside the U.S.: 20% of the cost.
Foot Care *(podiatry services)*	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing.	Foot exams and treatment if you have diabetes-related nerve damage and/or meet certain conditions: You pay nothing.
Hearing Services	Exam to diagnose and treat hearing and balance issues: You pay nothing. Routine hearing exam (for up to 1 every year): You pay nothing.	Exam to diagnose and treat hearing and balance issues: You pay nothing. Routine hearing exam (for up to 1 every year): You pay nothing.
Home Health Care	You pay nothing.	You pay nothing.
Mental Health Care	Inpatient visit: The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $100 copay per stay. • You pay nothing per day for days 91 and beyond. Outpatient group therapy visit: You pay nothing. Outpatient individual therapy visit: You pay nothing.	Inpatient visit: The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $100 copay per stay. • You pay nothing per day for days 91 and beyond. Outpatient group therapy visit: You pay nothing. Outpatient individual therapy visit: You pay nothing.

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing. Occupational therapy visit: $40 copay. Physical therapy and speech and language therapy visit: $40 copay.	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing. Occupational therapy visit: $15 copay. Physical therapy and speech and language therapy visit: $15 copay.
Outpatient Substance Abuse	Group therapy visit: $40 copay. Individual therapy visit: $40 copay.	Group therapy visit: $15 copay. Individual therapy visit: $15 copay.
Outpatient Surgery	Ambulatory surgical center: $150 copay. Outpatient hospital: $0-150 copay, depending on the service.	Ambulatory surgical center: $100 copay. Outpatient hospital: $0-100 copay, depending on the service.
Over-the-Counter Items	Not Covered.	Not Covered.
Prosthetic Devices *(braces, artificial limbs, etc.)*	Prosthetic devices: 20% of the cost. Related medical supplies: 20% of the cost.	Prosthetic devices: 20% of the cost. Related medical supplies: 20% of the cost.
Renal Dialysis	You pay nothing.	You pay nothing.
Transportation	Not covered.	Not covered.
Urgently Needed Services	$40 copay. Urgently needed services outside the U.S.: 20% of the cost.	$15 copay. Urgently needed services outside the U.S.: 20% of the cost.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-40 copay, depending on the service. Routine eye exam (for up to 1 every year): You pay nothing. Eyeglasses or contact lenses after cataract surgery: You pay nothing.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): $0-15 copay, depending on the service. Routine eye exam (for up to 1 every year): You pay nothing. Eyeglasses or contact lenses after cataract surgery: You pay nothing.

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Outpatient Rehabilitation	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing. Occupational therapy visit: You pay nothing. Physical therapy and speech and language therapy visit: You pay nothing.	Cardiac (heart) rehab services (for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks): You pay nothing. Occupational therapy visit: You pay nothing. Physical therapy and speech and language therapy visit: You pay nothing.
Outpatient Substance Abuse	Group therapy visit: You pay nothing. Individual therapy visit: You pay nothing.	Group therapy visit: You pay nothing. Individual therapy visit: You pay nothing.
Outpatient Surgery	Ambulatory surgical center: $50 copay. Outpatient hospital: $0-50 copay, depending on the service.	Ambulatory surgical center: $50 copay. Outpatient hospital: $0-50 copay, depending on the service.
Over-the-Counter Items	Not covered.	Not covered.
Prosthetic Devices *(braces, artificial limbs, etc.)*	Prosthetic devices: 20% of the cost. Related medical supplies: 20% of the cost.	Prosthetic devices: 20% of the cost. Related medical supplies: 20% of the cost.
Renal Dialysis	You pay nothing.	You pay nothing.
Transportation	Not covered.	Not covered.
Urgently Needed Services	You pay nothing. Urgently needed services outside the U.S.: 20% of the cost.	You pay nothing. Urgently needed services outside the U.S.: 20% of the cost.
Vision Services	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing. Routine eye exam (for up to 1 every year): You pay nothing. Eyeglasses or contact lenses after cataract surgery: You pay nothing.	Exam to diagnose and treat diseases and conditions of the eye (including yearly glaucoma screening): You pay nothing. Routine eye exam (for up to 1 every year): You pay nothing. Eyeglasses or contact lenses after cataract surgery: You pay nothing.

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
Preventive Care	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Preventive Care	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.	You pay nothing. Our plan covers many preventive services, including: • Abdominal aortic aneurysm screening • Alcohol misuse counseling • Bone mass measurement • Breast cancer screening (mammogram) • Cardiovascular disease (behavioral therapy) • Cardiovascular screenings • Cervical and vaginal cancer screening • Colorectal cancer screenings (Colonoscopy, Fecal occult blood test, Flexible sigmoidoscopy) • Depression screening • Diabetes screenings • HIV screening • Medical nutrition therapy services • Obesity screening and counseling • Prostate cancer screenings (PSA) • Sexually transmitted infections screening and counseling • Tobacco use cessation counseling (counseling for people with no sign of tobacco-related disease) • Vaccines, including Flu shots, Hepatitis B shots, Pneumococcal shots • "Welcome to Medicare" preventive visit (one-time) • Yearly "Wellness" visit Any additional preventive services approved by Medicare during the contract year will be covered.

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
INPATIENT CARE		
Inpatient Hospital Care	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $400 copay per stay. • You pay nothing per day for days 91 and beyond.	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $200 copay per stay. • You pay nothing per day for days 91 and beyond.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. • You pay nothing per day for days 1 through 20. • $100 copay per day for days 21 through 100.	Our plan covers up to 100 days in a SNF. You pay nothing.

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Hospice	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.	You pay nothing for hospice care from a Medicare-certified hospice. You may have to pay part of the cost for drugs and respite care. Hospice is covered outside of our plan. Please contact us for more details.
INPATIENT CARE		
Inpatient Hospital Care	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $100 copay per stay. • You pay nothing per day for days 91 and beyond.	The copays for hospital and skilled nursing facility (SNF) benefits are based on benefit periods. A benefit period begins the day you're admitted as an inpatient and ends when you haven't received any inpatient care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a SNF after one benefit period has ended, a new benefit period begins. You must pay the inpatient hospital deductible for each benefit period. There's no limit to the number of benefit periods. Our plan covers an unlimited number of days for an inpatient hospital stay. • $100 copay per stay. • You pay nothing per day for days 91 and beyond.
Inpatient Mental Health Care	For inpatient mental health care, see the "Mental Health Care" section of this booklet.	For inpatient mental health care, see the "Mental Health Care" section of this booklet.
Skilled Nursing Facility (SNF)	Our plan covers up to 100 days in a SNF. You pay nothing.	Our plan covers up to 100 days in a SNF. You pay nothing.

PRESCRIPTION DRUG BENEFITS

HOW MUCH DO I PAY?

For Part B drugs, such as chemotherapy drugs [1]: 0-20% of the cost.
Other Part B drugs [1]: 0-20% of the cost.

No cost sharing for Medicare-covered Part B injections administered in a physician's office. 20% cost sharing applies to all other Part B drugs.

INITIAL COVERAGE

After you pay your yearly deductible, you pay the following until your total yearly drug costs reach $3,310. Total yearly drug costs are the total drug costs paid by both you and our Part D plan. You may get your drugs at network retail pharmacies and mail order pharmacies.

	HealthPartners® Freedom Vital with Rx (Cost)		HealthPartners® Freedom Balance with Rx (Cost)	
Tier	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
STANDARD RETAIL COST-SHARING				
Tier 1 (Preferred Generic)	$8 copay	$24 copay	$7 copay	$21 copay
Tier 2 (Generic)	$20 copay	$60 copay	$18 copay	$54 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$300 copay	$100 copay	$300 copay
Tier 5 (Specialty Tier)	28% of the cost	Not offered	29% of the cost	Not offered
STANDARD MAIL ORDER COST-SHARING				
Tier 1 (Preferred Generic)	$8 copay	$24 copay	$7 copay	$21 copay
Tier 2 (Generic)	$20 copay	$60 copay	$18 copay	$54 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay	$47 copay	$141 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$300 copay	$100 copay	$300 copay
Tier 5 (Specialty Tier)	28% of the cost	Not Offered	29% of the cost	Not Offered
PREFERRED MAIL ORDER COST-SHARING				
Tier 1 (Preferred Generic)	$8 copay	$16 copay	$7 copay	$14 copay
Tier 2 (Generic)	$20 copay	$40 copay	$18 copay	$36 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$47 copay	$94 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$100 copay	$200 copay
Tier 5 (Specialty Tier)	28% of the cost	Not Offered	29% of the cost	Not Offered

	HealthPartners® Freedom Ultimate with Rx (Cost)		HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)	
Tier	**One-month supply**	**Three-month supply**	**One-month supply**	**Three-month supply**
STANDARD RETAIL COST-SHARING				
Tier 1 (Preferred Generic)	$7 copay	$21 copay	$7 copay	$21 copay
Tier 2 (Generic)	$16 copay	$48 copay	$15 copay	$45 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay	$40 copay	$120 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$300 copay	$85 copay	$255 copay
Tier 5 (Specialty Tier)	29% of the cost	Not Offered	29% of the cost	Not Offered
STANDARD MAIL ORDER COST-SHARING				
Tier 1 (Preferred Generic)	$7 copay	$21 copay	$7 copay	$21 copay
Tier 2 (Generic)	$16 copay	$48 copay	$15 copay	$45 copay
Tier 3 (Preferred Brand)	$47 copay	$141 copay	$40 copay	$120 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$300 copay	$85 copay	$255 copay
Tier 5 (Specialty Tier)	29% of the cost	Not Offered	29% of the cost	Not Offered
PREFERRED MAIL ORDER COST-SHARING				
Tier 1 (Preferred Generic)	$7 copay	$14 copay	$7 copay	$14 copay
Tier 2 (Generic)	$16 copay	$32 copay	$15 copay	$30 copay
Tier 3 (Preferred Brand)	$47 copay	$94 copay	$40 copay	$80 copay
Tier 4 (Non-Preferred Brand)	$100 copay	$200 copay	$85 copay	$170 copay
Tier 5 (Specialty Tier)	29% of the cost	Not Offered	29% of the cost	Not Offered

If you reside in a long-term care facility, you pay the same as at a retail pharmacy.
You may get drugs from an out-of-network pharmacy at the same cost as an in-network pharmacy.

COVERAGE GAP

Most Medicare drug plans have a coverage gap (also called the "donut hole"). This means that there's a temporary change in what you will pay for your drugs. The coverage gap begins after the total yearly drug cost (including what our plan has paid and what you have paid) reaches $3,310.

After you enter the coverage gap, you pay 45% of the plan's cost for covered brand name drugs and 58% of the plan's cost for covered generic drugs until your costs total $4,850, which is the end of the coverage gap. Not everyone will enter the coverage gap.

HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Under this plan, you may pay even less for the brand and generic drugs on the formulary. Your cost varies by tier. You will need to use your formulary to locate your drug's tier. See the chart that follows to find out how much it will cost you.

Tier	Drugs covered	One-month supply	Three-month supply
STANDARD RETAIL COST-SHARING			
Tier 1 (Preferred Generic)	All	$7 copay	$21 copay
Tier 2 (Generic)	All	$15 copay	$45 copay
Tier 3 (Preferred Brand)	All	50% of the cost	50% of the cost
STANDARD MAIL ORDER COST-SHARING			
Tier 1 (Preferred Generic)	All	$7 copay	$21 copay
Tier 2 (Generic)	All	$15 copay	$45 copay
Tier 3 (Preferred Brand)	All	55% of the cost	55% of the cost
PREFERRED MAIL ORDER COST-SHARING			
Tier 1 (Preferred Generic)	All	$7 copay	$14 copay
Tier 2 (Generic)	All	$15 copay	$30 copay
Tier 3 (Preferred Brand)	All	50% of the cost	50% of the cost

CATASTROPHIC COVERAGE

After your yearly out-of-pocket drug costs (including drugs purchased through your retail pharmacy and through mail order) reach $4,850, you pay the greater of:

- 5% of the cost, or
- $2.95 copay for generic (including brand drugs treated as generic) and a $7.40 copayment for all other drugs.

OPTIONAL BENEFITS (*You must pay an extra premium each month for these benefits*)

Package 1: Freedom Comprehensive Dental Benefit

	HealthPartners® Freedom Vital with Rx (Cost)	HealthPartners® Freedom Balance with Rx (Cost)
Benefits include:	• Comprehensive Dental • Preventive Dental	• Comprehensive Dental • Preventive Dental
How much is the monthly premium?	Additional $39.90 per month. You must keep paying your Medicare Part B premium and your $63.30 monthly plan premium.	Additional $39.90 per month. You must keep paying your Medicare Part B premium and your $134.20 monthly plan premium.
How much is the deductible?	$50 per year.	$50 per year.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,100 every year.	Our plan pays up to $1,100 every year.
Dental Services	You pay nothing for the following preventive dental benefits: • Up to 2 oral exams every year. • Up to 2 cleanings every year. • Up to 1 dental X-ray every year. Benefit includes coverage for preventive and diagnostic care and sealants, fillings, oral surgery, prosthetics and more.	You pay nothing for the following preventive dental benefits: • Up to 2 oral exams every year. • Up to 2 cleanings every year. • Up to 1 dental X-ray every year. Benefit includes coverage for preventive and diagnostic care and sealants, fillings, oral surgery, prosthetics and more.

Package 1: Freedom Comprehensive Dental Benefit

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Benefits include:	• Comprehensive Dental • Preventive Dental	• Comprehensive Dental • Preventive Dental
How much is the monthly premium?	Additional $39.90 per month. You must keep paying your Medicare Part B premium and your $212.50 monthly plan premium.	Additional $39.90 per month. You must keep paying your Medicare Part B premium and your $354.10 monthly plan premium.
How much is the deductible?	$50 per year.	$50 per year.
Is there a limit on how much the plan will pay?	Our plan pays up to $1,100 every year.	Our plan pays up to $1,100 every year.
Dental Services	You pay nothing for the following preventive dental benefits: • Up to 2 oral exams every year. • Up to 2 cleanings every year. • Up to 1 dental X-ray every year. Benefit includes coverage for preventive and diagnostic care and sealants, fillings, oral surgery, prosthetics and more.	You pay nothing for the following preventive dental benefits: • Up to 2 oral exams every year. • Up to 2 cleanings every year. • Up to 1 dental X-ray every year. Benefit includes coverage for preventive and diagnostic care and sealants, fillings, oral surgery, prosthetics and more.

ADDITIONAL INFORMATION ABOUT
HEALTHPARTNERS FREEDOM VITAL WITH RX (COST), HEALTHPARTNERS FREEDOM BALANCE WITH RX (COST), HEALTHPARTNERS FREEDOM ULTIMATE WITH RX (COST) AND HEALTHPARTNERS FREEDOM ULTIMATE WITH ENHANCED RX (COST)

The plan covers the following supplemental benefits:

	HealthPartners® Freedom Vital with Rx (Cost)	**HealthPartners® Freedom Balance with Rx (Cost)**
Remote Access Technologies	You pay nothing for the following: • Electronic visit (e-visit) • Scheduled Telephone Visit • virtuwell® • CareLine℠ Service Real-time Interactive Audio and Video Technologies: You pay a $15 copay for primary care visits and a $40 copay for specialist visits.	You pay nothing for the following: • Electronic visit (e-visit) • Scheduled Telephone Visit • virtuwell® • CareLine℠ Service Real-time Interactive Audio and Video Technologies: You pay a $15 copay per visit.
Fitness Benefit	The Silver&Fit® Exercise & Healthy Aging Program offers membership at a large network of fitness facilities or a home fitness option for members who prefer to work out at home. • You pay a $25 annual fee for membership at a Silver&Fit fitness facility. • You pay a $10 annual fee for the Silver&Fit Home Fitness Program.	The Silver&Fit® Exercise & Healthy Aging Program offers membership at a large network of fitness facilities or a home fitness option for members who prefer to work out at home. • You pay a $25 annual fee for membership at a Silver&Fit fitness facility. • You pay a $10 annual fee for the Silver&Fit Home Fitness Program.
Additional smoking and tobacco use cessation visits	You pay nothing for additional sessions of face-to-face counseling and interactive online and phone-based coaching.	You pay nothing for additional sessions of face-to-face counseling and interactive online and phone-based coaching.

The plan covers the following supplemental benefits:

	HealthPartners® Freedom Ultimate with Rx (Cost)	HealthPartners® Freedom Ultimate with Enhanced Rx (Cost)
Remote Access Technologies	You pay nothing for the following: • Electronic visit (e-visit) • Scheduled Telephone Visit • virtuwell® • CareLine℠ Service • Real-time Interactive Audio and Video Technologies	You pay nothing for the following: • Electronic visit (e-visit) • Scheduled Telephone Visit • virtuwell® • CareLine℠ Service • Real-time Interactive Audio and Video Technologies
Fitness Benefit	The Silver&Fit® Exercise & Healthy Aging Program offers membership at a large network of fitness facilities or a home fitness option for members who prefer to work out at home. • You pay a $25 annual fee for membership at a Silver&Fit fitness facility. • You pay a $10 annual fee for the Silver&Fit Home Fitness Program.	The Silver&Fit® Exercise & Healthy Aging Program offers membership at a large network of fitness facilities or a home fitness option for members who prefer to work out at home. • You pay a $25 annual fee for membership at a Silver&Fit fitness facility. • You pay a $10 annual fee for the Silver&Fit Home Fitness Program.
Additional smoking and tobacco use cessation visits	You pay nothing for additional sessions of face-to-face counseling and interactive online and phone-based coaching.	You pay nothing for additional sessions of face-to-face counseling and interactive online and phone-based coaching.

YOUR INFORMATION IS PROTECTED

For information on how HealthPartners manages and protects Health Information and Personal Information that you give us, how we will use and share that information, and how you may exercise your rights with regard to your Personal Information and Health Information, visit **healthpartners.com/public/privacy.**

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