
 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](http://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](http://www.healthcare.gov/sbc-glossary) or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <u>deductible</u>?</b>	In-network: \$0 Individual Out-of-network: \$10,000 Individual/\$20,000 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> .
<b>Are there services covered before you meet your <u>deductible</u>?</b>	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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other <u>deductibles</u> for specific services?</b>	No.	You don't have to meet <u>deductibles</u> for specific services.
<b>What is the <u>out-of-pocket limit</u> for this <u>plan</u>?</b>	In-network medical/pharmacy: \$3,000 Individual/\$6,000 Family Out-of-network medical/pharmacy: \$30,000 Individual/\$60,000 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.
<b>What is not included in the <u>out-of-pocket limit</u>?</b>	<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> .
<b>Will you pay less if you use a <u>network provider</u>?</b>	Yes. See <a href="http://www.healthpartners.com/performse">http://www.healthpartners.com/performse</a> 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.
<b>Do you need a <u>referral</u> to see a <u>specialist</u>?</b>	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
		Network Provider (You will pay the least)	Out-of-Network Provider (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: \$25 <u>copay</u> Convenience Care: \$10 <u>copay</u> virtuwell: No charge	Primary Office Visit: 50% <u>coinsurance</u> Convenience Care: 50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$25 <u>copay</u>	50% <u>coinsurance</u>	None
	<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)	10% <u>coinsurance</u> for x-ray/No charge for lab	50% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition  More information about <u>prescription drug coverage</u> is available at <a href="http://www.healthpartners.com/genericsadvantagerx">www.healthpartners.com/genericsadvantagerx</a>	Generic drugs	Formulary Low Cost: \$5 <u>copay</u> at retail, \$15 <u>copay</u> at mail Formulary High Cost: \$25 <u>copay</u> at retail, \$75 <u>copay</u> at mail Non-formulary: \$150 <u>copay</u> at retail, \$450 <u>copay</u> at mail	Formulary: 50% <u>coinsurance</u> at retail, mail not covered Non-formulary: 50% <u>coinsurance</u> at retail, mail not covered	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.
	Formulary brand drugs	\$60 <u>copay</u> at retail, \$180 <u>copay</u> at mail	50% <u>coinsurance</u> at retail, mail not covered	
	Non-formulary brand drugs	\$150 <u>copay</u> at retail, \$450 <u>copay</u> at mail	50% <u>coinsurance</u> at retail, mail not covered	
	<u>Specialty drugs</u>	20% <u>coinsurance</u>	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u>	\$200 <u>copay</u>	None
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	10% <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)	
	<u>Urgent care</u>	\$25 copay	\$25 copay	None
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	10% coinsurance	50% coinsurance	None
	Physician/surgeon fees	10% coinsurance	50% coinsurance	None
<b>If you need mental health, behavioral health, or substance use disorder services</b>	Outpatient services	\$25 copay	50% coinsurance	None
	Inpatient services	10% coinsurance	50% coinsurance	None
<b>If you are pregnant</b>	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	10% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	50% coinsurance	None
<b>If you need help recovering or have other special health needs</b>	<u>Home health care</u>	\$25 copay	50% coinsurance	120 visit limit
	<u>Rehabilitation services</u>	\$25 copay	50% coinsurance	None
	<u>Habilitation services</u>	\$25 copay	50% coinsurance	None
	<u>Skilled nursing care</u>	10% coinsurance	50% coinsurance	Limited to 120 day maximum per calendar year
	<u>Durable medical equipment</u>	10% coinsurance	50% coinsurance	None
	<u>Hospice services</u>	No charge	50% coinsurance	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days.
<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	10% coinsurance	Not covered	Limit of one pair of eyeglasses or contact lenses per year.
	Children's dental check-up	No charge	50% coinsurance	None

## Excluded Services & Other Covered Services:

### **Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery
- Dental care (Adult)
- Hearing aids(Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care
- Weight loss programs

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

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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, or the MN Dept of Health at 651-201-5100 / 1-800-657-3916, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://www.cciio.cms.gov). 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](http://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 or the MN Dept of Health at 651-201-5100 / 1-800-657-3916.

**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	None
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$10
Coinsurance	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,070</b>

### Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	None
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### 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*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,100
Coinsurance	\$90
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,210</b>

### Mia's Simple Fracture

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

■ The plan's overall deductible	None
■ Specialist copay	\$25
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

#### This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
 Diagnostic test (*x-ray*)  
 Durable medical equipment (*crutches*)  
 Rehabilitation services (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$300
Coinsurance	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$500</b>