The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call 1-800-883-2177 or visit us at www.healthpartners.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-883-2177 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
</table>
| What is the overall deductible?                         | In-network: $2,500 Individual/$5,000 Family contract  
Out-of-network: $10,000 Individual/$20,000 Family contract                                                                                                                                                                                     | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, the overall family deductible must be met before the plan begins to pay.                                                                                                                                                                        |
| Are there services covered before you meet your deductible? | Yes. Coinsurance marked with * in Common Medical Events and benefits with no charge are not subject to deductible                                                                                                                                 | This plan covers some items and services even if you haven’t yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| Are there other deductibles for specific services?       | No.                                                                                                                                                                                                     | You don’t have to meet deductibles for specific services.                                                                                                                                                                                                                                                                                                          |
| What is the out-of-pocket limit for this plan?           | In-network medical/pharmacy: $2,500 Individual/$5,000 Family contract  
Out-of-network medical/pharmacy: $30,000 Individual/$60,000 Family contract                                                                                                                                                                  | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, the overall family out-of-pocket limit must be met.                                                                                                                                                                                                 |
| What is not included in the out-of-pocket limit?         | Premium, balance-billed charges (unless balanced 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.                                                                                                                                                                                                                                                                                       |
| Will you pay less if you use a network provider?         | Yes. See www.healthpartners.com/sgachiev e or call 1-800-883-2177 for a list of in-network providers.                                                                                                   | This plan uses a provider network. You will pay less if you use a provider in the plan’s network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider’s charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
### Important Questions | Answers | Why This Matters:
--- | --- | ---
Do you need a referral to see a specialist? | No. | You can see the specialist you choose without a referral.

---

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>Network Provider (You will pay the least): Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance</td>
<td>Out-of-Network Provider (You will pay the most): Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
</tbody>
</table>

- **None**

Y

| **If you have a test** | Diagnostic test (x-ray, blood work) | 0% coinsurance | 50% coinsurance |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 50% coinsurance |

- **None**

**If you need drugs to treat your illness or condition**

More information about prescription drug coverage is available at [www.healthpartners.com/genericsadvantagerx](http://www.healthpartners.com/genericsadvantagerx)

| Generic drugs | Formulary: 0% coinsurance Non-formulary: Not covered | Formulary: 50% coinsurance at retail, mail not covered Non-formulary: Not covered |
| Formulary brand drugs | 0% coinsurance | 50% coinsurance at retail, mail not covered |
| Non-formulary brand drugs | Not covered | Not covered |
| Specialty drugs | 0% coinsurance | 50% coinsurance at retail, mail not covered |

31 day supply retail/ 93 day supply mail order

- **None**

**If you have outpatient surgery**

| Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 50% coinsurance |
| Physician/surgeon fees | 0% coinsurance | 50% coinsurance |

- **None**

**If you need immediate medical attention**

| Emergency room care | 0% coinsurance | 0% coinsurance |
| Emergency medical transportation | 0% coinsurance | 0% coinsurance |

Out-of-network services apply to the in-network deductible.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Urgent care</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Facility fee (e.g., hospital room)</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance use disorder services</strong></td>
<td>Outpatient services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Inpatient services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>No charge for prenatal/50% coinsurance for postnatal</td>
</tr>
<tr>
<td>Childbirth/delivery professional services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Childbirth/delivery facility services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td>Home health care</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>120 days per confinement</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Hospice services</td>
<td>0% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Children's glasses</td>
<td>0% coinsurance</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

**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
- 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, the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at 1-800-883-2177, the Department of Labor’s Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602.

Does this plan provide Minimum Essential Coverage? Yes.
If you don’t have Minimum Essential Coverage for a month, you’ll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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:
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): Dinëk'ehgo shika a'tohlwol ninisingo, kwiijigoh holne’ 1-800-883-2177.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.
### About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments, and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

#### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan’s overall deductible**: $2,500
- **Specialist coinsurance**: 0%
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Specialist office visits *(prenatal care)*
- Childbirth/Delivery Professional Services
- Childbirth/Delivery Facility Services
- Diagnostic tests *(ultrasounds and blood work)*
- Specialist visit *(anesthesia)*

**Total Example Cost** $12,700

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $60    |

**The total Peg would pay is** $2,560

#### Managing Joe’s type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- **The plan’s overall deductible**: $2,500
- **Specialist coinsurance**: 0%
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Primary care physician office visits *(including disease education)*
- Diagnostic tests *(blood work)*
- Prescription drugs
- Durable medical equipment *(glucose meter)*

**Total Example Cost** $7,300

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $60    |

**The total Joe would pay is** $2,560

#### Mia’s Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan’s overall deductible**: $2,500
- **Specialist coinsurance**: 0%
- **Hospital (facility) coinsurance**: 0%
- **Other coinsurance**: 0%

This EXAMPLE event includes services like:
- Emergency room care *(including medical supplies)*
- Diagnostic test *(x-ray)*
- Durable medical equipment *(crutches)*
- Rehabilitation services *(physical therapy)*

**Total Example Cost** $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,900</td>
</tr>
<tr>
<td>Copayments</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

| Limits or exclusions | $0     |

**The total Mia would pay is** $1,900
Statement of Nondiscrimination for Health Plan Members

Our Responsibilities:
We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

For Language or Communication Help:
Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)

If you have questions about our non-discrimination policy:
Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To File a Grievance:
If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)
Deutsch (German)

Français (French)
ATTENTION: Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (TTY: 711)

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)

Tagalog (Tagalog)
PAUNAWA: Kung nagsalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)

Oromoiffa (Oromo)
XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajajila gargaarsa afaanii, kanfaltidhaan ala, ni argama. Bilbiilaa 1-800-883-2177. (TTY: 711)

UnD (Karen)
ძურითფაქ — ფუტანი ქართულია. ფუტანი ქართული უცხოეულთა ურთიერთობა დაჭირათ. მერე 1-800-883-2177. (TTY: 711)

Romansh (Romansh)
Romansh Pienàscas clialalà, c'hedegh yëch gëmschëch, dënsë yëch c'hedeghëchs dënsë yëch clialalà dënsë yëch c'hedeghëchs. Pute 1-800-883-2177. (TTY: 711)

Deutsch (Pennsylvania Dutch)

Polski (Polish)
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)

Hindi (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता 'वाए उपलब्ध है। 1-800-883-2177. (TTY: 711)

Shqip (Albanian)
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)

Srpsko-hrvatski (Serbo-Croatian)

ગુજરાતી (Gujarati)
ધ્યાન દે: તમે ગુજરાતી બોલતા હો, તો નિઃચિક લાઇશ સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. કેલ કરો 1-800-883-2177. (TTY: 711)

آردو (Urdu)
خبردار: اگر آپ اردو بولتے ہیں تو آپ کو ہم کی مدد کی خدمات مفت میں دستیاب ہے۔ کال کریں 1-800-883-2177 (TTY: 711)

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)

ภาษาไทย (Thai)
เข้าสู่: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ โทร 1-800-883-2177. (TTY: 711)

Ελληνικά (Greek)
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)

Diné Bizaad (Navajo)
Dii baa akó nínízh: Dii saad bee yánilt’i’go Diné Bizaad, saad bee ák’áńida’áwo’deeg’, t’áá jiik’eh, éí ná hólí, koji’ hódíílnih 1-800-883-2177. (TTY: 711)