State of MN Minnesota Advantage Plan Cost Level 3, HealthPartners

Coverage Period: 01/01/2019-12/31/2019

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage for: Single and family | Plan Type: Tiered

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, visit www.healthpartners.com/segip or call 1-800-343-4404. 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 https://www.healthcare.gov/sbc-glossary or call 1-800-343-4404 to request a copy.

- Out of Network Point-of-Service (POS) coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and all dependent children, including college students, and spouses living out of area.
- The level of the office visit copayment for the employee and his or her family is dependent upon whether you have completed the Health Assessment in each Open Enrollment. Employees who have completed the Health Assessment and agreed to a follow-up from a Health Coach will receive a $5.00 reduction to their office visit copay.
- Employees who live and work out-of-area. Employees whose Permanent Residence and principal work location are outside the State of Minnesota and the service area of the Minnesota Advantage Health Plan may receive Cost Level 2 benefits in their area of Permanent Residence if they obtain services from the PPO of the Claims Administrator with whom they are enrolled. If a PPO provider is not available in their area, they may receive Cost Level 2 benefits from any licensed provider in their area. If PPO provider is available but not used, coverage will be limited to the point-of-service benefits ($350/$700 deductible, 30% coinsurance).

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$550/individual medical services Network $1,100/family medical services Network $350/individual medical services Out-of-Network $700/family medical services Out-of-Network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Well-child care, prenatal care and Network Preventive care services are covered before you meet your 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 "other" deductibles for specific services.
What is the out-of-pocket limit for this	$1,600/individual medical services Network and Out-of-Network $3,200/family medical services Network and Out-of-Network	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,

plan?	$800/individual prescription drugs Network $1,600/family prescription drugs Network	they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Will you pay less if you use a network provider?	Yes. See www.healthpartners.com/segip or call 1-800-343-4404 for a list of 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.
Do you need a referral to see a specialist?	Yes.	The plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist.

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	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60/$65 copay/visit	30% coinsurance (if permitted)	None
	Specialist visit	$60/$65 copay/visit	30% coinsurance (if permitted)	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	30% coinsurance (if permitted)	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance (if permitted)	

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	
If you need drugs to treat your illness or condition. A Retail Pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A Mail Service Pharmacy dispenses prescription drugs through the U.S. Mail. More information about prescription drug coverage is available at www.caremark.com	Preferred generic drugs	$14.00 copay/retail $28.00 copay/mail service $28.00 copay/90dayRx Retail at CVS pharmacy only	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
	Preferred brand drugs	$25.00 copay/retail $50.00 copay/mail service $50.00 copay/90dayRx Retail at CVS pharmacy only	Not covered	
	Non-preferred drugs	$50.00 copay/retail $100.00 copay/mail service $100.00 copay/90dayRx Retail at CVS pharmacy only	Not covered	
	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay/visit	30% coinsurance (if permitted)	None
	Physician/surgeon fees	No charge	30% coinsurance (if permitted)	No deductible applies in network.
If you need immediate medical attention	Emergency room care	$100 copay/visit	$100 copay/visit	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$60/$65 copay/visit	$60/$65 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$500 copay/admission	30% coinsurance (if permitted)	Copay waived if readmitted within 48 hours for same illness
	Physician/surgeon fees	No charge	30% coinsurance (if permitted)	No deductible applies in network
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$60/$65 copay/visit	30% coinsurance (if permitted)	None
	Inpatient services	$500 copay/admission	30% coinsurance (if permitted)	
If you are pregnant	Office visits Prenatal and Postnatal	No charge	30% coinsurance (if permitted)	No deductible applies in network
	Childbirth/delivery professional services	No charge	30% coinsurance (if permitted)	No deductible applies in network
	Childbirth/delivery facility services	$500 copay/admission	30% coinsurance (if permitted)	Deductible applies to mother only

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	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	None
	Rehabilitation services	$60/$65 copay/visit for occupational therapy $60/$65 copay/visit for physical therapy $60/$65 copay/visit for speech therapy	30% coinsurance for occupational therapy (if permitted) 30% coinsurance for physical therapy (if permitted) 30% coinsurance for speech therapy (if permitted)	None
	Habilitation services	$60/$65 copay/visit for occupational therapy $60/$65 copay/visit for physical therapy $60/$65 copay/visit for speech therapy	30% coinsurance for occupational therapy (if permitted) 30% coinsurance for physical therapy (if permitted) 30% coinsurance for speech therapy (if permitted)	None
	Skilled nursing care	No charge	30% coinsurance (if permitted)	No deductible applies in network.
	Durable medical equipment	20% coinsurance	30% coinsurance (if permitted)	None
	Hospice services	No charge	30% coinsurance (if permitted)	Coverage is limited to a maximum of 180 visit(s) per calendar year all providers combined. 2 per hospice episode maximum per lifetime for all networks. No deductible applies in network.
If your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance (if permitted)	None
	Children's glasses	Not covered	Not covered	No coverage for these services.
	Children's dental check-up	Not covered	Not covered	No coverage for these services.

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 (except as specified in Plan benefits) • Cosmetic Surgery (except as specified in Plan benefits)	• Dental Care (except as specified in Plan benefits) • Infertility Treatment • Long-Term Care	• Non-emergency care when traveling outside the U.S. • 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.)		
• Bariatric Surgery • Chiropractic Care	• Hearing Aids (as required by Minnesota State Law) • Private Duty Nursing	• 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: The contact information for those agencies is: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit 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 Claims Administrator by calling toll-free 1-800-343-4404 or if you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 888-393-2789.

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 MNsure/the Marketplace.

Statement of nondiscrimination

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.

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 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
1-800-537-7697 (TDD)

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး. တၢ်ကဟ့ၣ်နၤကျိာ်တၢ်မၤစၢၤကလီတဖၣ်နၣ်လီၤ. ကိ: 1-866-251-6744 လၢ TTYအဂီၢ်. ကိ: 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວได้, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį' béésh bee hodíílnih.

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 $550
- Specialist copayment $60
- Hospital (facility) coinsurance 0%
- Other coinsurance 20%

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	$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	$550
Copayments	$676
Coinsurance	$33
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$1,319

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

- The plan's overall deductible $550
- Specialist copayment $60
- Hospital (facility) coinsurance 0%
- Other coinsurance 20%

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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles	$520
Copayments	$903
Coinsurance	$177
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	$1,655

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

- The plan's overall deductible $550
- Specialist copayment $60
- Hospital (facility) coinsurance 0%
- Other coinsurance 20%

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:

Cost Sharing	
Deductibles	$550
Copayments	$720
Coinsurance	$164
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,434

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs.

The plan would be responsible for the other costs of these EXAMPLE covered services.