

 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 1-877-838-4949 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.healthcare.gov/sbc-glossary or call 1-877-838-4949 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$3,000 Individual/ \$6,000 Family Out-of-network: \$20,000 Individual/ \$40,000 Family	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 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, some 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 deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network medical/pharmacy: \$7,900 Individual/\$15,800 Family There is no out-of-network out-of-pocket limit .	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 , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.

Important Questions	Answers	Why This Matters:
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/smartcareind or call 1-877-838-4949 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.
Do you need a referral to see a specialist ?	No	You can see the in-network 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.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and 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 provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: \$25 copay , Deductible does not apply Convenience Care: \$10 copay , Deductible does not apply Virtuwell: No charge	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	\$75 copay , Deductible does not apply	50% coinsurance	None
	Preventive care/screening/immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% coinsurance	None
<p>If you need drugs to treat your illness or condition More information about prescription drug coverage is available at healthpartners.com/genericsadvantagerx</p>	Generic drugs	<p>Formulary Low Cost: \$5 copay/Per Prescription, Deductible does not apply at retail, \$15 copay/per 90 day supply, Deductible does not apply at mail</p> <p>Formulary High Cost: \$25 copay/Per Prescription, Deductible does not apply at retail, \$75 copay/per 90 day supply, Deductible does not apply at mail</p> <p>Non-formulary: Not covered</p>	<p>Formulary: 50% coinsurance at retail, mail not covered</p> <p>Non-formulary: Not covered</p>	<p>30 day supply retail / 90 day supply mail order. Non-formulary drugs are not covered unless an exception is granted.</p> <p>Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.</p>
	Formulary brand drugs	25% coinsurance	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	50% coinsurance	Not covered	Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor.
<p>If you have outpatient surgery</p>	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
<p>If you need immediate medical attention</p>	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible.
	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible.
	Urgent care	\$75 copay ,	50% coinsurance	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		Deductible does not apply		
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	\$25 copay , Deductible does not apply	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	Primary: \$25 copay , Deductible does not apply Specialty: \$75 copay , Deductible does not apply	50% coinsurance	120 visits per calendar year
	Rehabilitation services	Primary: \$25 copay , Deductible does not apply Specialty: \$75 copay , Deductible does not apply	50% coinsurance	None
	Habilitation services	Primary: \$25 copay , Deductible does not apply Specialty: \$75 copay , Deductible does not apply	50% coinsurance	None
	Skilled nursing care	25% coinsurance	50% coinsurance	120 days per calendar year

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	Hospice services	25% coinsurance	50% coinsurance	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days per episode.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	25% coinsurance	Not covered	Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per calendar year.
	Children's dental check-up	Not covered	Not covered	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 .)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) (and children) • Hearing aids (Adult) 	<ul style="list-style-type: none"> • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S. • Non-formulary drugs without a formulary exception • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care • Termination of pregnancy, except in cases of rape, incest, or danger to the life of the mother. • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Chiropractic care 		

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. 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.MNsure.org or call 1-855-366-7873.

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](#)? Not Applicable.

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 1-877-838-4949.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-838-4949.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-838-4949.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-838-4949.

————— *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)		Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)		Mia's Simple Fracture (in-network emergency room visit and follow up care)	
■ The plan's overall deductible	\$3,000	■ The plan's overall deductible	\$3,000	■ The plan's overall deductible	\$3,000
■ Specialist copay	\$75	■ Specialist copay	\$75	■ Specialist copay	\$75
■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	25%	■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%	■ Other coinsurance	25%	■ Other coinsurance	25%
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>	
Total Example Cost	\$12,800	Total Example Cost	\$5,600	Total Example Cost	\$2,800
In this example, Peg would pay:		In this example, Joe would pay:		In this example, Mia would pay:	
<i>Cost Sharing</i>		<i>Cost Sharing</i>		<i>Cost Sharing</i>	
Deductibles	\$3,000	Deductibles*	\$900	Deductibles*	\$2,300
Copayments	\$0	Copayments	\$800	Copayments	\$400
Coinsurance	\$2,300	Coinsurance	\$0	Coinsurance	\$0
<i>What isn't covered</i>		<i>What isn't covered</i>		<i>What isn't covered</i>	
Limits or exclusions	\$20	Limits or exclusions	\$20	Limits or exclusions	\$0
The total Peg would pay is	\$5,320	The total Joe would pay is	\$1,720	The total Mia would pay is	\$2,700



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 21 103K, 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)

<p>Español (<i>Spanish</i>) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)</p>	<p>ພາສາລາວ (<i>Laotian</i>) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຕະມັນມີໄວ້ອມໃຫ້ທ່ານ. ໂທສ 1-800-883-2177. (TTY: 711)</p>
<p>Hmoob (<i>Hmong</i>) LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)</p>	<p>Deutsch (<i>German</i>) ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)</p>
<p>Tiếng Việt (<i>Vietnamese</i>) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)</p>	<p>العربية (<i>Arabic</i>) ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177 (رقم هاتف الصم والبكم: 711)</p>
<p>繁體中文 (<i>Chinese</i>) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)</p>	<p>Français (<i>French</i>) ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)</p>
<p>Русский (<i>Russian</i>) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)</p>	<p>한국어 (<i>Korean</i>) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)</p>
<p>Af Soomaali (<i>Somali</i>) OGAYSIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)</p>	<p>Tagalog (<i>Tagalog</i>) PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)</p>

