

 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 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 800-883-2177 to request a copy.

| Important Questions   | Answers   | Why This Matters:   |
|---|---|---|
| <b>What is the overall <a href="#">deductible</a>?</b>                                | In-network: \$5,000 Individual/ \$15,000 Family<br>Out-of-network: \$10,000 Individual/ \$20,000 Family                                 | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of deductible expenses paid by all family members meets the overall family deductible.   |
| <b>Are there services covered before you meet your <a href="#">deductible</a>?</b>    | Yes, some preventive care services are covered before you meet your deductible.   | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> . |
| <b>Are there other <a href="#">deductibles</a> for specific services?</b>             | There are no other specific <a href="#">deductibles</a> .   | You don't have to meet <a href="#">deductibles</a> for specific services.   |
| <b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b> | In-network medical/pharmacy: \$8,600 Individual/\$17,200 Family<br>Out-of-network medical/pharmacy: \$30,000 Individual/\$60,000 Family | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.   |

| Important Questions  | Answers   | Why This Matters:   |
|--|---|---|
| What is not included in the <a href="#">out-of-pocket limit</a> ?            | <a href="#">Premium</a> , balance-billed charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't cover.    | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .   |
| Will you pay less if you use a <a href="#">network provider</a> ?            | Yes. See <a href="http://www.healthpartners.com/select">www.healthpartners.com/select</a> or call 1-800-883-2177 for a list of <a href="#">in-network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | No  | You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .   |



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  |
|--|--|---|--|---|
|  |  | <a href="#">Network Provider</a><br>(You will pay the least)  | <a href="#">Out-of-Network Provider</a><br>(You will pay the most)   |   |
| If you visit a health care <a href="#">provider's</a> office or clinic | Primary care visit to treat an injury or illness       | Primary Office Visit: \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply<br>Convenience Care: Not covered<br>Virtuwell: No charge | Primary Office Visit: 50% <a href="#">coinsurance</a><br>Convenience Care: 50% <a href="#">coinsurance</a> | None  |
|  | <a href="#">Specialist</a> visit                       | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply  | 50% <a href="#">coinsurance</a>  | None  |
|  | <a href="#">Preventive care/screening/immunization</a> | No charge   | 50% <a href="#">coinsurance</a>  | You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for. |
| If you have a test   | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | None  |

| Common Medical Event  | Services You May Need                          | What You Will Pay   |  | Limitations, Exceptions, and Other Important Information  |
|---|--|---|--|---|
|   |  | Network Provider<br>(You will pay the least)  | Out-of-Network Provider<br>(You will pay the most)   |   |
|   | Imaging (CT/PET scans, MRIs)                   | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | None  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://healthpartners.com/genericsadvantagerx">healthpartners.com/genericsadvantagerx</a> | Generic drugs                                  | <a href="#">Formulary</a> Low Cost: \$5 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at retail, \$15 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail<br><a href="#">Formulary</a> High Cost: \$25 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at retail, \$75 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail<br><a href="#">Non-formulary</a> : \$150 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply \$450 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail | <a href="#">Formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered<br><a href="#">Non-formulary</a> : 50% <a href="#">coinsurance</a> 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.<br>Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to an insured for a product or service, will not apply as out-of-pocket expense, to the extent permitted under state and federal law. |
|   | Formulary brand drugs                          | \$60 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at retail, \$180 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail   | 50% <a href="#">coinsurance</a> at retail, mail not covered  |   |
|   | Non-formulary brand drugs                      | \$150 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at retail, \$450 <a href="#">copay</a> , <a href="#">Deductible</a> does not apply at mail  | 50% <a href="#">coinsurance</a> at retail, mail not covered  |   |
|   | <a href="#">Specialty drugs</a>                | 20% <a href="#">coinsurance</a> , <a href="#">Deductible</a> does not apply   | Not covered  |   |
| <b>If you have outpatient surgery</b>   | Facility fee (e.g., ambulatory surgery center) | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | None  |
|   | Physician/surgeon fees                         | 30% <a href="#">coinsurance</a>   | 50% <a href="#">coinsurance</a>  | None  |

| Common Medical Event   | Services You May Need                            | What You Will Pay  |  | Limitations, Exceptions, and Other Important Information                              |
|--|--|--|--|---|
|  |  | Network Provider<br>(You will pay the least)                                     | Out-of-Network Provider<br>(You will pay the most)                               |   |
| If you need immediate medical attention                                | <a href="#">Emergency room care</a>              | 30% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>  | Out-of-network services apply to the in-network deductible.                           |
|  | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>  | 30% <a href="#">coinsurance</a>  | Out-of-network services apply to the in-network deductible.                           |
|  | <a href="#">Urgent care</a>                      | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply | Out-of-Network services apply to the in-network deductible.                           |
| If you have a hospital stay  | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | None  |
|  | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | None  |
| If you need mental health, behavioral health, or substance abuse needs | Outpatient services                              | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a>  |   |
|  | Inpatient services                               | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | None  |
| If you are pregnant  | Office visits                                    | No charge  | 50% <a href="#">coinsurance</a>  | Depending on the type of services, a copayment, coinsurance, or deductible may apply. |
|  | Childbirth/delivery professional services        | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | None  |
|  | Childbirth/delivery facility services            | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | None  |
| If you need help recovering or have other special health needs         | <a href="#">Home health care</a>                 | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a>  | 120 visits per calendar year  |
|  | <a href="#">Rehabilitation services</a>          | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a>  | None  |
|  | <a href="#">Habilitation services</a>            | \$65 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply | 50% <a href="#">coinsurance</a>  | None  |
|  | <a href="#">Skilled nursing care</a>             | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | 120 days per calendar year  |
|  | <a href="#">Durable medical equipment</a>        | 30% <a href="#">coinsurance</a>  | 50% <a href="#">coinsurance</a>  | None  |

| Common Medical Event                   | Services You May Need            | What You Will Pay                            |  | Limitations, Exceptions, and Other Important Information   |
|--|----------------------------------|--|--|--|
|  |                                  | Network Provider<br>(You will pay the least) | Out-of-Network Provider<br>(You will pay the most) |  |
|  | <a href="#">Hospice services</a> | No charge                                    | 50% <a href="#">coinsurance</a>                    | 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% <a href="#">coinsurance</a>                    | None   |
|  | Children's glasses               | 30% <a href="#">coinsurance</a>              | 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       | No charge                                    | 50% <a href="#">coinsurance</a>                    | None   |

### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other <a href="#">excluded services</a> .)  |   |   |
|--|---|---|
| <ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Bariatric surgery</li> <li>• Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery</li> <li>• Infertility treatment</li> </ul> | <ul style="list-style-type: none"> <li>• Long-term care</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Non-formulary drugs without a formulary exception</li> <li>• Private-duty nursing</li> </ul> | <ul style="list-style-type: none"> <li>• Routine foot care</li> <li>• Weight loss programs</li> </ul> |

| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.) |  |  |
|--|--|--|
| <ul style="list-style-type: none"> <li>• Chiropractic care</li> </ul>  | <ul style="list-style-type: none"> <li>• Dental care (Children)</li> </ul> | <ul style="list-style-type: none"> <li>• Routine eye care (Adult)</li> </ul> |

**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](http://www.dol.gov/ebsa/healthreform) or MN Dept of Health at 651-201-5100 / 1-800-657-3916. 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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) or 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 [plan](#), [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): 打这带 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 <a href="#">plan's</a> overall <a href="#">deductible</a> | \$5,000 |
| ■ <a href="#">Specialist copay</a>                              | \$65    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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> |
|---------------------------|-----------------|

In this example, Peg would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles</a>       | \$5,000        |
| <a href="#">Copayments</a>        | \$0            |
| <a href="#">Coinsurance</a>       | \$2,200        |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$70           |
| <b>The total Peg would pay is</b> | <b>\$7,270</b> |

### Managing Joe's type 2 Diabetes

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$5,000 |
| ■ <a href="#">Specialist copay</a>                              | \$65    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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> |
|---------------------------|----------------|

In this example, Joe would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$900          |
| <a href="#">Copayments</a>        | \$1,100        |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$20           |
| <b>The total Joe would pay is</b> | <b>\$2,020</b> |

### Mia's Simple Fracture

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

|   |         |
|---|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$5,000 |
| ■ <a href="#">Specialist copay</a>                              | \$65    |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 30%     |
| ■ Other <a href="#">coinsurance</a>                             | 30%     |

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> |
|---------------------------|----------------|

In this example, Mia would pay:

| <a href="#">Cost Sharing</a>      |                |
|-----------------------------------|----------------|
| <a href="#">Deductibles*</a>      | \$2,300        |
| <a href="#">Copayments</a>        | \$300          |
| <a href="#">Coinsurance</a>       | \$0            |
| <i>What isn't covered</i>         |                |
| Limits or exclusions              | \$0            |
| <b>The total Mia would pay is</b> | <b>\$2,600</b> |