

 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](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 1-877-838-4949 to request a copy.

Important Questions	Answers	Why This Matters:
<p><b>What is the overall <a href="#">deductible</a>?</b></p>	<p>Select Tier: \$100 Single/ \$300 Family                      Standard Tier: \$1,000 Single/ \$3,000 Family                      Out of Network:\$10,000 Single/                      \$20,000 Family</p>	<p>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 <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a>.</p>
<p><b>Are there services covered before you meet your <a href="#">deductible</a>?</b></p>	<p>Yes, some preventive care services are covered before you meet your deductible.</p>	<p>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>.</p>
<p><b>Are there other <a href="#">deductibles</a> for specific services?</b></p>	<p>There are no other specific <a href="#">deductibles</a>.</p>	<p>You don't have to meet <a href="#">deductibles</a> for specific services.</p>
<p><b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b></p>	<p>Select Tier: \$6,500 Single/ \$13,000 Family                      Standard Tier: \$6,500 Single/ \$13,000 Family                      Out of Network:\$30,000 Single/                      \$60,000 Family</p>	<p>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.</p>

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/tieredchoice">www.healthpartners.com/tieredchoice</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
		Select Tier (You will pay the least)	Standard Tier (You will pay more)	Out-of-network (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: \$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply Convenience Care: \$5 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply Virtuwell: No charge	Primary Office Visit: \$50 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply Convenience Care: \$5 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply Virtuwell: No charge	Primary Office Visit: 50% <a href="#">coinsurance</a> Convenience Care: 50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	\$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$50 <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	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

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Select Tier (You will pay the least)	Standard Tier (You will pay more)	Out-of-network (You will pay the most)	
					<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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need drugs to treat your illness or condition 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> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$15 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail <a href="#">Formulary</a> High Cost: \$25 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$75 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail <a href="#">Non-formulary</a> : \$150 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply \$450 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail	<a href="#">Formulary</a> Low Cost: \$5 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$15 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail <a href="#">Formulary</a> High Cost: \$25 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$75 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail <a href="#">Non-formulary</a> : \$150 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply \$450 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail	<a href="#">Formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered <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. 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> /Per Prescription, <a href="#">Deductible</a> does not	\$60 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not	50% <a href="#">coinsurance</a> at retail, mail not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Select Tier (You will pay the least)	Standard Tier (You will pay more)	Out-of-network (You will pay the most)	
		apply at retail, \$180 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail	apply at retail, \$180 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail		
	Non-formulary brand drugs	\$150 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$450 <a href="#">copay</a> /per 93 day supply, <a href="#">Deductible</a> does not apply at mail	\$150 <a href="#">copay</a> /Per Prescription, <a href="#">Deductible</a> does not apply at retail, \$450 <a href="#">copay</a> /per 93 day supply, <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>	20% <a href="#">coinsurance</a>	Not covered	Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</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>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Urgent care</a>	\$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$50 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$50 <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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</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
		Select Tier (You will pay the least)	Standard Tier (You will pay more)	Out-of-network (You will pay the most)	
If you need mental health, behavioral health, or substance abuse needs	Outpatient services	\$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$10 <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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you are pregnant	Office visits	No charge	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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	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>	\$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$50 <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>	\$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$50 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	50% <a href="#">coinsurance</a>	None
	<a href="#">Habilitation services</a>	\$10 <a href="#">copay</a> /Per Visit, <a href="#">Deductible</a> does not apply	\$50 <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>	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>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	No charge	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 .
	Children's eye exam	No charge	No charge	50% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, and Other Important Information
		Select Tier (You will pay the least)	Standard Tier (You will pay more)	Out-of-network (You will pay the most)	
If your child needs dental or eye care	Children's glasses	30% <a href="#">coinsurance</a>	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	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>	\$100
■ <a href="#">Specialist copay</a>	\$10
■ 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>
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In this example, Peg would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$100
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$3,600
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$3,770</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>	\$100
■ <a href="#">Specialist copay</a>	\$10
■ 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>
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In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$100
<a href="#">Copayments</a>	\$600
<a href="#">Coinsurance</a>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$920</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>	\$100
■ <a href="#">Specialist copay</a>	\$10
■ 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>
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In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$100
<a href="#">Copayments</a>	\$60
<a href="#">Coinsurance</a>	\$700
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$860</b>