**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 844-732-3545 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 844-732-3545 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: $4,100 Individual/ $8,200 Family<br>Out-of-network: $10,000 Individual/ $20,000 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, the overall family deductible must be met before the plan begins to pay. |
| **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?** | There are no other specific deductibles. | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | In-network medical/pharmacy: $4,300 Individual/$8,600 Family<br>Out-of-network medical/pharmacy: $30,000 Individual/$60,000 Family | 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. |

| 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/openaccess 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. |
| **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: 0% coinsurance<br>Convenience Care: 0% coinsurance<br>Virtuwell: 0% coinsurance | Primary Office Visit: 50% coinsurance<br>Convenience Care: 50% coinsurance | None |
| | Specialist visit | 0% coinsurance | 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) | 0% coinsurance | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 0% coinsurance | 50% coinsurance | None |
| | Generic drugs | Formulary: 0% | Formulary: 50% | 31 day supply retail / 93 day supply mail order. |

| 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 need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at healthpartners.com/genericsadvantagerx | | coinsurance Non-formulary: 20% coinsurance | coinsurance at retail, mail not covered Non-formulary: 50% coinsurance at retail, mail not covered | Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month. |
| | Formulary brand drugs | 0% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Non-formulary brand drugs | 20% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Specialty drugs | 0% coinsurance | 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) | 0% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 0% coinsurance | 50% coinsurance | None |
| **If you need immediate medical attention** | Emergency room care | 0% coinsurance | 0% coinsurance | Out-of-network services apply to the in-network deductible. |
| | Emergency medical transportation | 0% coinsurance | 0% coinsurance | Out-of-network services apply to the in-network deductible. |
| | Urgent care | 0% coinsurance | 0% coinsurance | Out-of-Network services apply to the in-network deductible. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 0% coinsurance | 50% coinsurance | None |
| | Physician/surgeon fees | 0% coinsurance | 50% coinsurance | None |
| **If you need mental health, behavioral health, or substance abuse needs** | Outpatient services | 0% coinsurance | 50% coinsurance | |
| | Inpatient services | 0% 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 | 0% 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) | |
| | Childbirth/delivery facility services | 0% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | 0% coinsurance | 50% coinsurance | 120 visits per benefit year |
| | Rehabilitation services | 0% coinsurance | 50% coinsurance | None |
| | Habilitation services | 0% coinsurance | 50% coinsurance | None |
| | Skilled nursing care | 0% coinsurance | 50% coinsurance | 90 days per benefit year |
| | Durable medical equipment | 0% coinsurance | 50% coinsurance | None |
| | Hospice services | 0% coinsurance | 50% coinsurance | 15 days per lifetime . |
| If your child needs dental or eye care | Children's eye exam | No charge | 50% coinsurance | None |
| | Children's glasses | 0% coinsurance | Not covered | Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per benefit year. |
| | Children's dental check-up | No charge | No charge | 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.)**

- Acupuncture
- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery
- 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
- Dental care (Children)
- 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: Your plan at 1-800-883-2177, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, South Dakota Division of Insurance at 1-605-773-3563. 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 the South Dakota Division of Insurance at 1-605-773-3563.

**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): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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 | $4,100 |
| 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:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $4,100 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $70 |
| **The total Peg would pay is** | **$4,170** |

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

| | |
|---|---|
| The plan's overall deductible | $4,100 |
| 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** | **$5,600** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $1,900 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,920** |

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

| | |
|---|---|
| The plan's overall deductible | $4,100 |
| 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** | **$2,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles* | $2,800 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$2,800** |