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 1-800-883-2177 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 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $750 Individual, $1,500 Family Out-of-network: $1,500 Individual, $3,000 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. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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: $4,000 Individual, $8,000 Family Out-of-network: $8,000 Individual, $16,000 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, 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. Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) will not be applied towards satisfying your out-of-pocket maximums. Copay assistance dollars for specialty medications will not apply to your out-of-pocket maximums.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Because you do not 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 https://www.healthpartners.com/daikinapplied 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 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, & 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	Office Visit: $25 copay* Convenience Care: $25 copay* virtuwell: No charge	Office Visit: 40% coinsurance after deductible Convenience Care: 40% coinsurance after deductible virtuwell: Not covered	None
	Specialist visit	$35 copay*	40% coinsurance after deductible	None

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 (You will pay the most)	
	Preventive care/screening/ immunization	No charge	Not covered	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)	x-ray: 10% coinsurance after deductible lab work: No charge	40% coinsurance after deductible	Lab/X-Ray services performed in an office setting is no charge, deductible does not apply; if performed as an outpatient service 10% coinsurance after deductible is met. Failure to obtain pre-certification may result in non-coverage or reduced benefits for the following services: Diagnosis of Sleep Disorders, Gene Expression Profiling for Managing Breast Cancer Treatment and Genetic Testing for Cancer Susceptibility. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Imaging (CT/PET scans, MRIs)	10% coinsurance after deductible	40% coinsurance after deductible	Failure to obtain pre-certification may result in non-coverage or reduced benefits for the following services: MRI Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.express-scripts.com**	Tier 1- Typically Generic	Retail: $10 copay* Mail-Order: $20 copay*	Not covered	Contact Express Scripts at 855-747-5792 Or www.express-scripts.com Pharmacy out-of-pocket limit included under the medical out-of-pocket limit. Days Supply Limit: Retail: 31 days Mail: 90 days Specialty: 30 days
	Tier 2- Typically Preferred/ Formulary Brand	Retail: $35 copay* Mail-Order: $70 copay*		
	Tier 3- Typically Non-Preferred/ Non-Formulary Drugs	Retail: $55 copay* Mail-Order: $110 copay*		
	Tier 4- Typically Specialty Drugs	$135 copay*	Not covered	Please see "Important Questions" regarding the plan's out-of-pocket limit. The plan has a

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 (You will pay the most)	
				specialty pharmacy copay assistance program. Copays for certain specialty medications may be set to the max of the current plan design or any available manufacturer-funded copay assistance.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	$250 copay then 10% coinsurance after deductible	$250 copay then 10% coinsurance after deductible	If admitted, ER Copay is waived. Failure to obtain pre-certification for Emergency Admission (Requires Plan notification no later than 2 business days after admission) may result in non-coverage or reduced benefits.
	Emergency medical transportation	10% coinsurance after deductible	10% coinsurance after deductible	
	Urgent care	$40 copay*	40% coinsurance after deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance after deductible	40% coinsurance after deductible	None
	Physician/surgeon fees	10% coinsurance after deductible	40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Mental/Behavioral Health Office Visit/Outpatient Health Facility Visit $25 copay*/Visit	Mental/Behavioral Health Office Visit/Outpatient Health Facility Visit 40% coinsurance after deductible	No limits. Check with your plan administrator to learn about your EAP benefits.
	Inpatient services	10% coinsurance after deductible	40% coinsurance after deductible	Failure to obtain pre-authorization may result in non-coverage or reduced benefits.
If you are pregnant	Office visits	Prenatal: $25 copay* for initial visit, then no cost share Postnatal: No cost share	40% coinsurance after deductible	Copay applies to initial office visit. There may be other levels of cost share that are contingent on how services are provided,

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 (You will pay the most)	
				please see your formal contract of coverage for a complete explanation.
	Childbirth/delivery professional services	10% coinsurance after deductible	40% coinsurance after deductible	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Failure to obtain pre-certification may result in non-coverage or reduced benefits for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay).
	Childbirth/delivery facility services	10% coinsurance after deductible	40% coinsurance after deductible	Applies to inpatient facility. Other cost shares may apply depending on the services provided. Failure to obtain pre-certification may result in non-coverage or reduced benefits for OB delivery stays beyond the Federal Mandate minimum LOS (including newborn stays beyond the mother's stay).
If you need help recovering or have other special health needs	Home health care	No charge	40% coinsurance after deductible	120 visits in-network and out-of-network combined.
	Rehabilitation services	$35 copay*	40% coinsurance after deductible	Coverage is limited to 30 days maximum per Benefit Period combined for Occupational and Physical Therapies combined In-Network and Out-of-Network Providers. Coverage is limited to 30 days maximum per Benefit Period for Speech Therapy combined In-Network and Out-of-Network Providers. Costs may vary by site of service. You should refer to your formal contract of coverage for details.
	Habilitation services	$35 copay*	40% coinsurance after deductible	Habilitation visits count towards your Rehabilitation limit.
	Skilled nursing care	10% coinsurance after deductible	40% coinsurance after deductible	60 days per year, in-network and out-of-network combined
	Durable medical equipment	10% coinsurance after deductible	10% coinsurance after deductible	Pre-certification may be required.
	Hospice services	No charge	40% coinsurance after deductible	None

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 (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Coverage is limited to one Routine Exam performed by a physician as part of a yearly Routine Physical and allow one Routine Eye Exam if performed by Ophthalmologist, Optician, Optometrist or Pediatric Ophthalmologist.
	Children's glasses	Not covered	Not covered	None
	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.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Private duty nursing (in home)

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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? **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	$750
Specialist copay	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$750
Copayments	$10
Coinsurance	$1,100
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,920**

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

The plan's overall deductible	$750
Specialist copay	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$750
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$4,450**

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

The plan's overall deductible	$750
Specialist copay	$35
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$750
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$1,150**