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?	**$2,000/Single or $4,000/Family** In-Network Tier I & II **$2,250/Single or $4,500/Family** Tier III Out-of-Network **Note: These are combined deductibles and will apply to satisfy Tier III deductible** Employer HRA contribution of $750 (single)/$1,500 (family), helps cover the cost of the deductible	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. 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.	None
What is the out-of-pocket limit for this plan?	**$3,000/Single or $6,000/Family** In-Network Tier I & II **$4,000/Single or $8,000/Family** Tier III, OON **Pharmacy Benefit:** $1,500/Single or $3,000/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?	Copayments for certain services, premiums, balance-billing charges, 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 https://www.healthpartners.com/networks 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 do not need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan. If you choose to see a Tier II or III provider, you will be responsible for the difference in the deductible, coinsurance, and out-of-pocket maximum amounts.

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	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Specialist visit	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Preventive care/screening/ immunization	**Tier I & II:** 100% covered	**Tier III:** 40% coinsurance after deductible	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. Routine hearing and vision exams covered 1 per calendar year.

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 have a test	Diagnostic test (x-ray, blood work)	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	**Tier I:** $8 copay/prescription **Tier II:** $24 copay/prescription	**Tier III:** No Coverage	Covers up to a 34-day supply / 102 day supply retail **90 day supply of generic maintenance drugs for 2 copays ($16) at Tier I pharmacies** **Non-formulary drugs require step therapy and prior authorization in order to be covered. Then Formulary drug benefit would apply**
	Formulary brand drugs	**Tier I:** $30 copay/prescription **Tier II:** $50 copay/prescription		
	Non-formulary brand drugs	No Coverage		
	Specialty drugs	**Tier I:** 20% coinsurance deductible does not apply, up to $125 max copay per prescription **Tier II:** 30% coinsurance		

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)	
		deductible does not apply, up to $125 max copay per prescription		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Physician/surgeon fees	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	**Tier I & II:** 20% coinsurance after deductible	**Tier III:** 20% coinsurance after in-network deductible	None
	Emergency medical transportation	**Tier I & II:** 20% coinsurance deductible does not apply	**Tier III:** 20% coinsurance deductible does not apply	
	Urgent care	**Tier I & II:** 20% coinsurance after deductible	**Tier III:** 20% coinsurance after in-network deductible	
If you have a hospital stay	Facility fee (e.g., hospital room)	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 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)	
	Physician/surgeon fees	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Inpatient services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
If you are pregnant	Prenatal Exams & Well-child Exams, (birth to age 6)	**Tier I & II:** 100% covered	**Tier III:** 40% coinsurance after deductible	Cost sharing does not apply to certain preventive services. Depending on the type of services, coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	
	Childbirth/delivery facility services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	
If you need help recovering or have	Home health care	**Tier I:** 20% coinsurance after deductible	**Tier III:** 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)	
other special health needs		**Tier II:** 30% coinsurance after deductible		
	Rehabilitation services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Habilitation services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
	Skilled nursing care	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	120 visits per calendar year
	Durable medical equipment	**Tier I & II:** 20% coinsurance deductible does not apply	**Tier III:** 20% coinsurance deductible does not apply	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	Hospice services	**Tier I:** 20% coinsurance after deductible **Tier II:** 30% coinsurance after deductible	**Tier III:** 40% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	**Tier I & II:** Covered at 100%	**Tier III:** 40% coinsurance after deductible	Coverage limited to one exam/year.
	Children's glasses	No Coverage	No Coverage	No coverage for these services
	Children's dental check-up	No Coverage	No Coverage	No coverage for these services

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	• Long-term care	• Routine foot care
• Dental care (Adult)	• Private-duty nursing	• Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture	• Hearing aids	• Non-emergency care when traveling outside the U.S.
• Bariatric surgery	• Infertility treatment	
• Chiropractic care		• 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 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	$4,000
Employer's HRA Contribution	-$1,500
Hospital (facility) coinsurance	20%
Specialist coinsurance	20%
Other coinsurance	20%

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	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$0
Coinsurance	$1,760
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is*	**$4,320**

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

The plan's overall deductible	$2,000
Employer's HRA Contribution	-$750
Hospital (facility) coinsurance	20%
Specialist coinsurance	20%
Other coinsurance	20%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$2,000
Copayments	$0
Coinsurance	$1,080
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is*	**$2,330**

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

The plan's overall deductible	$2,000
Employer's HRA Contribution	-$750
Hospital (facility) coinsurance	20%
Specialist coinsurance	20%
Other coinsurance	20%

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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,150**