



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 <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
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 <u>deductible</u>	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . 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 <u>deductibles</u> 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 <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

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

 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
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you visit a health care <u>provider's office</u> or clinic	Primary care visit to treat an injury or illness	Office Visit: \$25 <u>copay</u> * Convenience Care: \$25 <u>copay</u> * Virtuwell: No charge	Office Visit: 40% <u>coinsurance</u> after <u>deductible</u> Convenience Care: 40% <u>coinsurance</u> after <u>deductible</u> Virtuwell: Not covered	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)	
	<u>Specialist</u> visit	\$35 <u>copay</u> *	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	x-ray: 10% <u>coinsurance</u> after <u>deductible</u> lab work: No charge	40% <u>coinsurance</u> after <u>deductible</u>	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% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	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 <u>prescription drug coverage</u> is available at Rx Carveout	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
	Tier 2- Typically Preferred/Formulary Brand	Retail: \$35 copay* Mail-Order: \$70 copay*		Pharmacy out-of-pocket limit included under the medical out-of-pocket limit.
	Tier 3- Typically Non-Preferred/Non-Formulary Drugs	Retail: \$55 copay* Mail-Order: \$110 copay*		Days Supply Limit: Retail: 31 days Mail: 90 days Specialty: 30 days

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)	
	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 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% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
	Physician/surgeon fees	10% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 copay then 10% <u>coinsurance after deductible</u>	\$250 copay then 10% <u>coinsurance after deductible</u>	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.
	<u>Emergency medical transportation</u>	10% <u>coinsurance after deductible</u>	10% <u>coinsurance after deductible</u>	Out-of-network services apply to the in-network deductible
	<u>Urgent care</u>	\$40 <u>copay*</u>	40% <u>coinsurance after deductible</u>	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
	Physician/surgeon fees	10% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	\$25 <u>copay*</u>	40% <u>coinsurance</u>	No limits. Check with your plan administrator to learn about your EAP benefits.
	Inpatient services	10% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	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% <u>coinsurance after deductible</u>	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% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	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% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	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	<u>Home health care</u>	No charge	40% <u>coinsurance after deductible</u>	120 visits in-network and out-of-network combined.
	<u>Rehabilitation services</u>	\$35 <u>copay*</u>	40% <u>coinsurance after deductible</u>	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.
	<u>Habilitation services</u>	\$35 <u>copay*</u>	40% <u>coinsurance after deductible</u>	Habilitation visits count towards your Rehabilitation limit.
	<u>Skilled nursing care</u>	10% <u>coinsurance after deductible</u>	40% <u>coinsurance after deductible</u>	60 day maximum - in-network and out-of-network combined.
	<u>Durable medical equipment</u>	10% <u>coinsurance after deductible</u>	10% <u>coinsurance after deductible</u>	Pre-certification may be required
	<u>Hospice services</u>	No charge	40% <u>coinsurance after deductible</u>	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.)

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| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Long-term care | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Hearing aids | <ul style="list-style-type: none"> • Chiropractic care • Infertility treatment • Private duty nursing | <ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • Routine eye care (Adult) |
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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, 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 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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$2,010

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$800
The total Joe would pay is	\$1,200

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
<u>Deductibles</u>	\$750
<u>Copayments</u>	\$250
<u>Coinsurance</u>	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,100