




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 <u>deductible</u>? | In-network: \$3,500 Individual, \$7,000 Family contract Out-of-network: \$7,000 Individual, \$14,000 Family contract | 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 policy, the overall family <u>deductible</u> must be met before the <u>plan</u> begins to pay. |
| Are there services covered before you meet your <u>deductible</u>? | 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 <u>deductibles</u> for specific services? | No. | You don't have to meet <u>deductibles</u> for specific services. |
| What is the <u>out-of-pocket limit</u> for this <u>plan</u>? | In-network: \$6,900 Individual, \$13,800 Family contract Out-of-network: \$14,000 Individual, \$28,000 Family contract | 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> , the overall family <u>out-of-pocket limit</u> must be met. |
| What is not included in the <u>out-of-pocket limit</u>? | <u>Premium</u> , balance-billed charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover. | 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/OpenAccess 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</u> office or clinic | Primary care visit to treat an injury or illness | Office Visit: 20% <u>coinsurance</u> Convenience Care: 20% <u>coinsurance</u> Virtuwell: 0% <u>coinsurance</u> | Office Visit: 50% <u>coinsurance</u> Convenience Care: 50% <u>coinsurance</u> Virtuwell: Not covered | None |
| | <u>Specialist</u> visit | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | <u>Preventive care/screening/immunization</u> | No charge | 50% <u>coinsurance</u> | 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) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | <u>Imaging</u> (CT/PET scans, MRIs) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html | Generic drugs | <u>Formulary</u> : 20% <u>coinsurance</u> Non-formulary: 30% <u>coinsurance</u> | Not covered | 31 day supply retail / 93 day supply mail order Formulary Generic: /\$15 max copay; Non-Formulary Generic: /\$125 max copay; Formulary Brand: /\$75 max copay; Non-Formulary Brand: /\$125 max copay |
| | Formulary brand drugs | 25% <u>coinsurance</u> | | |
| | Non-formulary brand drugs | 30% <u>coinsurance</u> | | |
| | <u>Specialty drugs</u> | 30% <u>coinsurance</u> | Not covered | \$250 maximum copay per prescription per month |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need immediate medical attention | <u>Emergency room care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Out-of-network services apply to the in-network deductible |
| | <u>Emergency medical transportation</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Out-of-network services apply to the in-network deductible |
| | <u>Urgent care</u> | 20% <u>coinsurance</u> | 20% <u>coinsurance</u> | Out-of-network services apply to the in-network deductible |
| If you have a hospital | Facility fee (e.g., hospital room) | 20% <u>coinsurance</u> | 50% <u>coinsurance</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) | |
| stay | Physician/surgeon fees | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need mental health, behavioral health, or substance use disorder services | Outpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Inpatient services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you are pregnant | Office visits | No charge | 50% <u>coinsurance</u> | None |
| | Childbirth/delivery professional services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Childbirth/delivery facility services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If you need help recovering or have other special health needs | Home health care | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | In-network: 120 visit maximum; Out-of-network: 120 visit maximum |
| | Rehabilitation services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Out-of-network: 20 visit limit/year |
| | Habilitation services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | Out-of-network: 20 visit limit/year |
| | Skilled nursing care | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | 120 day maximum |
| | Durable medical equipment | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| | Hospice services | 20% <u>coinsurance</u> | 50% <u>coinsurance</u> | None |
| If your child needs dental or eye care | Children's eye exam | No charge | 50% <u>coinsurance</u> | None |
| | 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 <u>Plan</u> Generally Does NOT Cover (Check your policy or <u>plan</u> document for more information and a list of any other <u>excluded services</u> .) | | |
|--|--|--|
| <ul style="list-style-type: none"> Bariatric surgery Cosmetic surgery Dental care (Adult) | <ul style="list-style-type: none"> Long-term care Private-duty nursing | <ul style="list-style-type: none"> Routine foot care Weight loss programs |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <u>plan</u> document.) | | |
| <ul style="list-style-type: none"> Acupuncture Chiropractic care | <ul style="list-style-type: none"> Hearing aids Infertility treatment | <ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. 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): Dinekehgo 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 <u>plan's</u> overall <u>deductible</u> | \$3,500 |
| ■ <u>Specialist</u> <u>coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 | \$12,700 |
|---------------------------|-----------------|

In this example, Peg would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$3,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$1,400 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$4,960 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,500 |
| ■ <u>Specialist</u> <u>coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 | \$5,600 |
|---------------------------|----------------|

In this example, Joe would pay:

| <u>Cost Sharing</u> | |
|-----------------------------------|----------------|
| <u>Deductibles</u> | \$3,500 |
| <u>Copayments</u> | \$0 |
| <u>Coinsurance</u> | \$400 |
| <u>What isn't covered</u> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$3,920 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$3,500 |
| ■ <u>Specialist</u> <u>coinsurance</u> | 20% |
| ■ Hospital (facility) <u>coinsurance</u> | 20% |
| ■ Other <u>coinsurance</u> | 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 | \$2,800 |
|---------------------------|----------------|

In this example, Mia would pay:

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