




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 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 undefined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$5,500 Individual/\$11,000 Family 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, 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, 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
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: \$7,000 Individual/\$14,000 Family 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, 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 <a href="#">out-of-pocket limit</a> ?	<a href="#">Premium</a> , balance-billed charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthpartners.com/openaccess">www.healthpartners.com/openaccess</a> or call 1-800-883-2177 for a list of <a href="#">in-network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware, your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No	You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: 30% <a href="#">coinsurance</a> Convenience Care: 30% <a href="#">coinsurance</a> Virtuwell: 0% <a href="#">coinsurance</a>	Primary Office Visit: 50% <a href="#">coinsurance</a> Convenience Care: 50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Generic drugs	<a href="#">Formulary</a> : 30%	<a href="#">Formulary</a> : 50%	

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)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://healthpartners.com/genericsadvantagerx">healthpartners.com/genericsadvantagerx</a>		<a href="#">coinsurance</a> <b>Non-formulary:</b> Not covered	<a href="#">coinsurance</a> at retail, mail not covered <b>Non-formulary:</b> Not covered at retail, mail not covered	31 day supply retail / 93 day supply mail order. Non-formulary drugs are not covered unless an exception is granted. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month. Select Preventive Drugs: Generic: No charge; Brand: \$60 copay. Any amounts paid or reimbursed by a third party, including but not limited to: point of service rebates, manufacturer coupons, manufacturer debit cards or other forms of direct reimbursement to an insured for a product or service, will not apply as out-of-pocket expense, to the extent permitted under state and federal law.
	Formulary brand drugs	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered at retail, mail not covered	
<b>If you have outpatient surgery</b>	<a href="#">Specialty drugs</a>	30% <a href="#">coinsurance</a>	Not covered	Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor.
	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Urgent care</a>	30% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a>	Out-of-Network services apply to the in-network deductible.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or</b>	Outpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Inpatient services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	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)	
substance abuse needs	Office visits	No charge	50% <a href="#">coinsurance</a>	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you are pregnant	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Home health care	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	120 visits per calendar year
If you need help recovering or have other special health needs	<a href="#">Rehabilitation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Habituation services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	120 days per calendar year
	<a href="#">Durable medical equipment</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days per episode .
	Children's eye exam	No charge	50% <a href="#">coinsurance</a>	None
If your child needs dental or eye care	Children's glasses	30% <a href="#">coinsurance</a>	Not covered	Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per calendar year.
	Children's dental check-up	No charge	50% <a href="#">coinsurance</a>	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
- Long-term care
- Routine foot care
- Bariatric surgery
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery
- Non-formulary drugs without a formulary exception
- Private-duty nursing
- Infertility treatment

### Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Dental care (Children)
- 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform or MN Dept of Health at 651-201-5100 / 1-800-657-3916. 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 MN Dept of Health at 651-201-5100 / 1-800-657-3916.

### 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 ): 打这帮 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](#) \$5,500
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- [Other coinsurance](#) 30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$5,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$7,070</b>

### Managing Joe's type 2 Diabetes

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

- The [plan's overall deductible](#) \$5,500
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- [Other coinsurance](#) 30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$1,000
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$2,920</b>

### Mia's Simple Fracture

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

- The [plan's overall deductible](#) \$5,500
- [Specialist coinsurance](#) 30%
- [Hospital \(facility\) coinsurance](#) 30%
- [Other coinsurance](#) 30%

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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$2
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>