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.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $25 Individual, $75 Family Out-of-network: $750 Individual, $2,100 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 in Common Medical Events 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 medical: $1,200 Individual, $2,400 Family Out-of-network medical: $3,500 Individual, $8,500 Family Pharmacy: $1,200 Individual, $2,400 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Pharmacy copays, pharmacy coinsurance, premium, balance-billed charges (unless balanced billing is prohibited), and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.

Important Questions	Answers	Why This Matters:
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 pay the least if you use a provider in Level 1. You pay more if you use a provider in Level 2. 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 for Level 1/$40 copay for Level 2 Convenience Care: $10 copay virtuwell: No charge for the first three visits and $10 copay thereafter	Office Visit: 35% coinsurance Convenience Care: 35% coinsurance virtuwell: Not covered	None
	Specialist visit	$25 copay for Level 1/$40 copay for Level 2	35% coinsurance	None
	Preventive care/screening/ immunization	No charge	Immunizations not covered, well child not covered, preventive care not covered, 35% coinsurance for other services	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)	0% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	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 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	Formulary: $12 copay* at retail, $24 copay* at mail Non-formulary: Not covered	Formulary: 35% coinsurance at retail, mail not covered Non-formulary: Not covered	30 day supply retail / 90 day supply mail order
	Formulary brand drugs	$35 copay* at retail, $70 copay* at mail		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	20% coinsurance*	35% coinsurance at retail, mail not covered	$200 maximum copay per prescription per month
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$125 copay for Level 1/$275 copay for Level 2	35% coinsurance	None
	Physician/surgeon fees	0% coinsurance	35% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay	Not covered	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	$40 copay	$40 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$125 copay per admit for Level 1/$275 copay per admit for Level 2	35% coinsurance	None
	Physician/surgeon fees	0% coinsurance	35% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$25 copay	35% coinsurance	None
	Inpatient services	$125 copay per admit for Level 1/$275 copay per admit for Level 2	35% coinsurance	None
If you are pregnant	Office visits	No charge	35% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	35% coinsurance	None
	Childbirth/delivery facility services	$125 copay per admit for Level 1/$275 copay per admit for Level 2	35% coinsurance	None
If you need help recovering or have other	Home health care	Therapies: $40 copay IV: 0% coinsurance	35% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum

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)	
special health needs	Rehabilitation services	$25 copay for Level 1/$40 copay for Level 2	35% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	$25 copay for Level 1/$40 copay for Level 2	Not covered	None
	Skilled nursing care	$125 copay per admit	35% coinsurance	120 maximum days per confinement
	Durable medical equipment	20% coinsurance	35% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	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 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
- Long-term care
- Private-duty nursing
- 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
- Infertility treatment
- 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 following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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 following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

Does this plan provide Minimum Essential Coverage? **Yes**.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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	$25
Specialist copay	$25
Hospital (facility) copay	$125
Other copay	$125

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	$25
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$585**

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

The plan's overall deductible	$25
Specialist copay	$25
Hospital (facility) copay	$125
Other copay	$125

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	**$7,300**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$25
Copayments	$900
Coinsurance	$300
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,285**

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

The plan's overall deductible	$25
Specialist copay	$25
Hospital (facility) copay	$125
Other copay	$125

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	$25
Copayments	$300
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$525**