




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:
<p>What is the overall <u>deductible</u>?</p>	<p>\$3,200/Single or \$6,400/Family In-Network Tier I & II \$6,000/Single of \$12,000/Family Tier III, OON</p> <p>Note: These are combined deductibles and will apply to satisfy Tier III deductible</p> <p>Employer HSA contribution of \$850 (single)/\$1,700 (family), helps cover the cost of the deductible</p>	<p>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>.</p>
<p>Are there services covered before you meet your <u>deductible</u>?</p>	<p>Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u>.</p>	<p>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/.</p>
<p>Are there other <u>deductibles</u> for specific services?</p>	<p>No.</p>	<p>You don't have to meet <u>deductibles</u> for specific services.</p>

Important Questions	Answers	Why This Matters:
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	\$4,000/Single or \$8,000/Family In-Network Tier I & II \$10,000/Single or \$20,000/Family Tier III, OON Pharmacy Benefit: Cost goes toward deductible	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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Copayments</u> for certain services, <u>premiums</u> , <u>balance-billing</u> charges, 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/centracare or call 1-800-565-0629 for a list of <u>network providers</u> .	This <u>plan</u> uses a provider <u>network</u> . You will pay less if you use a <u>provider</u> in the plan's <u>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 provider's charge and what your plan 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 do not need a referral to see a specialist	You can see the <u>specialist</u> you choose without permission from this <u>plan</u> . 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
		<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	Tier I: 20% <u>coinsurance</u> after deductible Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
	<u>Specialist</u> visit	Tier I: 20% <u>coinsurance</u> after deductible Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> 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)	
	Preventive care/screening/immunization	Tier I & II: 100% covered	Tier III: 50% 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.
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: 50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	Tier I: 20% coinsurance after deductible Tier II: 30% coinsurance after deductible	Tier III: 50% 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: 20% coinsurance after deductible. Preventive Rx: 100% covered Tier II: 30% coinsurance after deductible	Tier III: No Coverage	Covers up to a 34-day supply / 102 day supply retail 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: 20% coinsurance after deductible. Preventive Rx: 100% covered Tier II: 30% coinsurance after deductible		Diabetic supplies: Tier I: 20% coinsurance after deductible, Tier II: 30% coinsurance after deductible, Tier III: No Coverage Injectables (including insulin): Tier I: 20% coinsurance after deductible, Tier II: 30% coinsurance after deductible, Tier III: No Coverage
	Non-formulary brand drugs	Not covered		
	Specialty drugs	Tier I: 20% coinsurance after deductible.	Tier III: No Coverage	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)	
		Tier II: 30% <u>coinsurance</u> after deductible		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
	Physician/surgeon fees	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
If you need immediate medical attention	<u>Emergency room care</u>	Tier I & II: 20% <u>coinsurance</u> after deductible	Tier III: 20% <u>coinsurance</u> after in-network deductible	None
	<u>Emergency medical transportation</u>	Tier I & II: 20% <u>coinsurance</u> after deductible	Tier III: 20% <u>coinsurance</u> after in-network deductible	None
	<u>Urgent care</u>	Tier I & II: 20% <u>coinsurance</u> after deductible	Tier III: 20% <u>coinsurance</u> after in-network deductible	None
If you have a hospital stay	Facility fee (e.g., hospital room)	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
	Physician/surgeon fees	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> 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)	
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
	Inpatient services	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
If you are pregnant	Prenatal Exams & Well-child Exams, (birth to age 6)	Tier I & II: 100% covered	Tier III: 50% <u>coinsurance</u> after deductible	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	<u>Cost sharing</u> does not apply to certain <u>preventive services</u> . Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	<u>Home health care</u>	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> 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)	
	<u>Rehabilitation services</u>	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
	<u>Habilitation services</u>	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
	<u>Skilled nursing care</u>	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	120 visits per calendar year
	<u>Durable medical equipment</u>	Tier I & II: 20% <u>coinsurance</u> after deductible	Tier III: 20% <u>coinsurance</u> after deductible	Excludes vehicle modifications, home modifications, exercise, and bathroom equipment.
	<u>Hospice services</u>	Tier I: 20% <u>coinsurance</u> after deductible. Tier II: 30% <u>coinsurance</u> after deductible	Tier III: 50% <u>coinsurance</u> after deductible	None
If your child needs dental or eye care	Children's eye exam	Tier I & II: Covered at 100%	Tier III: 50% <u>coinsurance</u> 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.)		
<ul style="list-style-type: none"> • 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 plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids
- 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 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, kwijjigo 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 \$6,400
- The **plan's** HSA contribution \$1,700
- Specialist coinsurance 20%
- Hospital (facility) 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	\$6,400
Copayments	\$0
Coinsurance	\$1,440
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$6,200

Managing Joe's type 2 Diabetes

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

- The **plan's** overall deductible \$3,200
- The **plan's** HSA contribution \$850
- Specialist coinsurance 20%
- Hospital (facility) 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*	\$3,200
Copayments	\$0
Coinsurance	\$920
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$3,330

Mia's Simple Fracture

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

- The **plan's** overall deductible \$3,200
- The **plan's** HSA contribution \$850
- Specialist coinsurance 20%
- Hospital (facility) 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	\$1,050