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: $400 Individual/$800 Family Out-of-network: $800 Individual/$1,600 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 under What You Will Pay 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?	Yes.	$25 dental expense calendar year deductible. There are no other specific deductibles.
What is the out-of-pocket limit for this plan?	In-network: $2,400 Individual/$4,800 Family Out-of-network: $4,800 Individual/ $9,600 Family Prescription Drugs: $5,000 individual/$10,000 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.
What is not included in the out-of-pocket limit?	Any required premiums for coverage and health care this plan does not cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
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 will pay less if you use a provider in the plan's network. 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: $20 copay* Convenience Care: $20 copay* virtuwell: 0% coinsurance	Office Visit: 30% coinsurance Convenience Care: 30% coinsurance virtuwell: Not covered	None
	Specialist visit	$20 copay*	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	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)	20% coinsurance	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	30% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.proactrx.com	Generic drugs	15% copayment subject to minimum copayment Retail: $5 copayment Mail Order: $10 copayment	Not covered	34-day supply limitation for retail prescriptions; 90-day supply limitation for mail order prescriptions and certain approved retail pharmacies.
	Preferred brand drugs	15% copayment subject to minimum copayment Retail: $20 copayment (formulary) Mail Order: $40 copayment (formulary)		
	Non-Preferred brand drugs	15% copayment subject to minimum copayment Retail: $35 copayment (non-formulary) Mail Order: $70 copayment (non-formulary)		

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)	
	Specialty drugs	15% copayment subject to minimum copayment $40 copayment (Brand Name – formulary) $70 copayment (Brand Name –non-formulary)	Not covered	30-day supply limitation available only through Noble Pharmacy. www.proactrx.com
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay*	$100 copay*	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$20 copay*	$20 copay*	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	None
	Physician/surgeon fees	20% coinsurance	30% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$20 copay*	30% coinsurance	None
	Inpatient services	20% coinsurance	Not covered	None
If you are pregnant	Office visits	No charge	30% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	In and out of network combined maximum of 180 visits.
	Rehabilitation services	$30 copay	30% coinsurance	None
	Habilitation services	$30 copay	30% coinsurance	None
	Skilled nursing care	20% coinsurance	Not covered	120 day maximum
	Durable medical equipment	20% coinsurance	30% coinsurance	Wigs are covered for Alopecia Areata and hair loss due to chemo/radiation. No other medical conditions will apply.
	Hospice services	20% coinsurance	30% 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 your child needs dental or eye care	Children's eye exam	No charge	30% coinsurance	Effective 1/1/2022, coverage is through the medical plan.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	$25 deductible per calendar year. 0% coinsurance.	Not covered	$1,500 calendar year maximum does not apply to individuals under age 19. $1,500 lifetime maximum for orthodontia does not apply to non-cosmetic orthodontia benefits for individuals under age 19. Please refer to the plan SPD for additional detail.

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
- Cosmetic surgery
- Non-network inpatient services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care
- Weight loss programs
- Orthotics

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

- Bariatric surgery (when medically necessary for treatment of obesity).
- Chiropractic care
- Dental care
- Hearing aids (Cochlear Implants or Bone Anchored Hearing Aids only)
- Infertility Treatment
- 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, 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	**$400**
Specialist copay	**$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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$400
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$70
The total Peg would pay is	**$2,470**

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

The plan's overall deductible	**$400**
Specialist copay	**$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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$100
What isn't covered	
Limits or exclusions	$3,500
The total Joe would pay is	**$4,200**

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

The plan's overall deductible	**$400**
Specialist copay	**$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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$400
Copayments	$200
Coinsurance	$300
What isn't covered	
Limits or exclusions	$10
The total Mia would pay is	**$910**