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](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-800-883-2177 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-network: $0&lt;br&gt;Out-of-network: $200 Individual, $600 Family</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Out of network Emergency room services, Emergency medical transportation and Durable medical equipment are not subject to the deductible.</td>
<td>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>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-network medical: $2,500 Individual, None Family&lt;br&gt;Out-of-network medical: $2,500 Individual, None Family&lt;br&gt;Pharmacy: $300 Individual</td>
<td>The out-of-pocket limit is the most you could pay in a year for covered services.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premium, balance billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See <a href="https://www.healthpartners.com/uofmga">https://www.healthpartners.com/uofmga</a> or call 1-800-883-2177 for a list of in-network providers.</td>
<td>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.</td>
</tr>
</tbody>
</table>
## Important Questions

### Answers

<table>
<thead>
<tr>
<th>Do you need a referral to see a specialist?</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why This Matters:</td>
<td>You can see the specialist you choose without a referral.</td>
</tr>
</tbody>
</table>

⚠️ All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

### Common Medical Event

<table>
<thead>
<tr>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care visit to treat an injury or illness</td>
<td>Office Visit: $10 copay per visit  Convenience Care: $5 copay per visit  Virtuwell: $5 copay per visit</td>
<td>Office Visit: 20% coinsurance  Convenience Care: 20% coinsurance  Virtuwell: Not covered</td>
</tr>
<tr>
<td>Specialist visit</td>
<td>$10 copay per visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>20% coinsurance for immunizations, No charge for well child, 20% coinsurance for preventive care, 20% coinsurance for other services</td>
</tr>
</tbody>
</table>

<p>| <strong>If you have a test</strong> | | |
| Diagnostic test (x-ray, blood work) | No charge | No charge | None |
| Imaging (CT/PET scans, MRIs) | No charge | 20% coinsurance | None |</p>
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Generic drugs</strong></td>
<td>Formulary: $10 copay/prescription at retail, $20 copay/90-day prescription at mail.</td>
<td>20% coinsurance at retail, mail not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-formulary: $50 copay/prescription at retail, $100 copay/90-day prescription at mail. 100% coverage after copay for all.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Formulary brand drugs</strong></td>
<td>$25 copay/prescription at retail, $50 copay/90-day prescription at mail. 100% coverage after copay for all.</td>
<td>20% coinsurance at retail, mail not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Non-formulary brand drugs</strong></td>
<td>$50 copay/prescription at retail, $100 copay/90-day prescription at mail. 100% coverage after copay for all.</td>
<td>20% coinsurance at retail, mail not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialty drugs</strong></td>
<td>Formulary: $10 copay/prescription.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Brand: $25 copay/90-day prescription.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-formulary: $50 copay/prescription.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>100% coverage after copay for all.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Facility fee (e.g., ambulatory surgery center)</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td><strong>Physician/surgeon fees</strong></td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency room care</strong></td>
<td>$40 copay per visit</td>
<td>$40 copay per visit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Deductible does not apply.</td>
<td>None</td>
</tr>
</tbody>
</table>

If you need drugs to treat your illness or condition

34 day supply retail / 90 day supply mail order
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
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<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance. Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10 copay per visit</td>
<td>No charge</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder services</td>
<td>Outpatient services</td>
<td>$10 copay per visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>No charge</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$10 copay per visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$10 copay per visit</td>
<td>20% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>20% coinsurance</td>
<td>20% coinsurance. Deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>No charge</td>
<td>No charge</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cosmetic surgery</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine foot care</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>
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 (limited to one external hearing aid for each ear every three years)
- 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 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 Health Insurance Assistance Team (HIAT) at the U.S. Department of Health and Human Services at 1-888-393-2789.

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:
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, kwiiijigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby (9 months of in-network pre-natal care and a hospital delivery)</th>
<th>Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)</th>
<th>Mia's Simple Fracture (in-network emergency room visit and follow up care)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The plan’s overall deductible</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Specialist copay</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Hospital (facility) coinsurance</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other coinsurance</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

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 | $0 | $0 | $0 |
| Copayments | $30 | $700 | $80 |
| Coinsurance | $0 | $300 | $200 |

What isn’t covered:

- Limits or exclusions: $60
- The total Peg would pay is: $90

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 | $0 | $0 | $0 |
| Copayments | $700 | $80 |
| Coinsurance | $300 | $200 |

What isn’t covered:

- Limits or exclusions: $60
- The total Joe would pay is: $1,060

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 | $0 | $0 | $0 |
| Copayments | $80 | $200 |
| Coinsurance | $200 |

What isn’t covered:

- Limits or exclusions: $60
- The total Mia would pay is: $280

The plan would be responsible for the other costs of these EXAMPLE covered services.