HealthPartners: Key Embedded $2,500 Plus (Silver)

Coverage Period: 01/01/2015-12/31/2015

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.healthpartners.com** or by calling 1-877-838-4949.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$2,500** Individual/**$7,500** Family Out-of-network: **$5,000** Individual/**$15,000** Family Copays are not subject to deductible	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. In-network medical/pharmacy: **$6,350** Individual/**$13,200** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	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**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **in-network providers**, see **healthpartners.com/individualnetwork** or call 1-877-838-4949.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at **www.cciio.cms.gov** or call 1-877-838-4949 to request a copy.

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: $30 copay for the first three visits and 20% coinsurance thereafter Convenience Care: $15 copay for the first three visits and 20% coinsurance thereafter virtuwell: No charge	Primary Office Visit: 60% coinsurance Convenience Care: 60% coinsurance virtuwell: Not covered	First three office or urgent care visits are a copay. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance. Services received by Indian Health Provider are covered at 100%.
	Specialist visit	$30 copay for the first three visits and 20% coinsurance thereafter	60% coinsurance	First three office or urgent care visits are a copay. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance
	Other practitioner office visit	20% coinsurance	60% coinsurance	none
	Preventive care/screening/immunization	No charge	60% coinsurance	none
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	60% coinsurance	none
	Imaging (CT/PET scans, MRIs)	20% coinsurance	60% coinsurance	none

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at **www.healthpartners.com/genericsadvantagerx**.	Generic drugs	Formulary: $12 copay at retail, $36 copay at mail Non-formulary: Not covered	Formulary: 60% coinsurance at retail, mail not covered Non-formulary: Not covered	30 day supply retail / 90 day supply mail order. Non-formulary drugs are not covered unless an exception is granted.
	Formulary brand drugs	20% coinsurance	60% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	20% coinsurance	100% coinsurance at retail, mail not covered	none
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	60% coinsurance	none
	Physician/surgeon fees	20% coinsurance	60% coinsurance	none
If you need immediate medical attention	Emergency room services	$150 copay	$150 copay	You pay $150 copay after deductible. Out of Network services apply to in-network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	none
	Urgent care	$30 copay for the first three visits and 20% coinsurance thereafter	60% coinsurance	none
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	60% coinsurance	none

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Common Medical Event	Services You May Need	Your cost if you use a In-Network Provider	Your cost if you use a Out-Of-Network Provider	Limitations & Exceptions
	Physician/surgeon fee	20% coinsurance	60% coinsurance	none
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$30 copay for the first three visits and 20% coinsurance thereafter	60% coinsurance	Copays do not apply to services performed in a hospital.
	Mental/Behavioral health inpatient services	20% coinsurance	60% coinsurance	none
	Substance use disorder outpatient services	$30 copay for the first three visits and 20% coinsurance thereafter	60% coinsurance	Copays do not apply to services performed in a hospital.
	Substance use disorder inpatient services	20% coinsurance	60% coinsurance	none
If you are pregnant	Prenatal and postnatal care	No charge	60% coinsurance	none
	Delivery and all inpatient services	20% coinsurance	60% coinsurance	none
If you need help recovering or have other special health needs	Home health care	20% coinsurance	60% coinsurance	none
	Rehabilitation services	20% coinsurance	60% coinsurance	none
	Habilitation services	20% coinsurance	60% coinsurance	none
	Skilled nursing care	20% coinsurance	60% coinsurance	Limited to 120 days per confinement
	Durable medical equipment	20% coinsurance	60% coinsurance	none
	Hospice service	20% coinsurance	60% coinsurance	5 days for respite/30 combined for respite and continuous
If your child needs dental or eye care	Eye exam	No charge	60% coinsurance	none
	Glasses	20% coinsurance	Not covered	Limited to one pair of eyeglasses per year.
	Dental check-up	Not covered	Not covered	none

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

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Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)(and children)
- Hearing aids(Adult)
- Infertility treatment
- Long-term care
- Non-formulary drugs without a formulary exception
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-877-838-4949. You may also contact your state insurance department at **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**.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your state insurance department at **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**.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-877-838-4949.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-838-4949.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-838-4949.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-838-4949.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. Cost sharing or "Patient pays" amounts are based on self-only coverage.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3,840
- **Patient pays** $3,700

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$2,500
Copays	$0
Coinsurance	$1,000
Limits or exclusions	$200
Total	**$3,700**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,270
- **Patient pays** $3,130

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2,500
Copays	$150
Coinsurance	$400
Limits or exclusions	$80
Total	**$3,130**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.