

PEIP Advantage HSA Single Plan Cost Level 3

HealthPartners

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2021

Coverage for: Single Coverage Only | Plan Type: HSA



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, visit www.healthpartners.com or call 1-800-883-2177. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copay](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-883-2177 to request a copy.

- **Out of Network** Point-of-Service (POS) coverage is available only for members whose permanent residence is outside the State of Minnesota and outside the service areas of the health plans participating in Advantage. This category includes employees temporarily residing outside Minnesota on temporary assignment or paid leave [including sabbatical leaves] and all dependent children, including college students, and spouses living out of area.
- **Employees who live and work out-of-area.** Employees whose Permanent Residence and principal work location are outside the State of Minnesota and the service area of the PEIP Advantage Health Plan may receive Cost Level 2 benefits in the area of their Permanent Residence if they obtain services from the PPO of the Claims Administrator with whom they are enrolled. If a PPO provider is not available in their area, they may receive Cost Level 2 benefits from any licensed provider in their area. If PPO provider is available but not used, coverage will be limited to the point-of-service benefits (\$1500 Single/\$3000 Family deductible, 30% coinsurance).

Important Questions	Answers	Why this Matters:
What is the overall deductible ?	\$3,000 medical and drug per individual network \$1,500 medical and drug per individual out-of-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay.
Are there services covered before you meet your deductible ?	Yes. Well-child care, prenatal care and network preventive care services are covered before you meet your deductible .	This plan covers some items and services even if you haven't yet met the deductible amount. But a copay 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?	\$4,000 medical and drug per individual network and out-of-network	The out-of-pocket limit is the most you could pay in a year for covered services.
What is not included in the out-of-pocket limit ?	Premiums , balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .

Will you pay less if you use an in-network provider ?	Yes. See www.healthpartners.com or call 1-800-883-2177 for a list of 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 laboratory work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	Yes.	The plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan's permission before you see the specialist .



All [copay](#) 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	\$105 copay /visit	30% coinsurance (if permitted)	None
	Specialist visit	\$105 copay /visit	30% coinsurance (if permitted)	None
	Preventive care/screening/immunization	No charge	No charge (if permitted)	You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	30% coinsurance (if permitted)	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	30% coinsurance (if permitted)	
If you need drugs to treat your illness or condition. A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A mail service pharmacy dispenses prescription drugs through the U.S. Mail.	Preferred generic drugs	\$30 copay /retail \$60 copay /mail service \$60 copay /90dayRx retail	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
	Preferred brand drugs	\$50 copay /retail \$100 copay /mail service \$100 copay /90dayRx retail	No charge	
	Non-preferred drugs	\$75 copay /retail \$150 copay /mail service \$150 copay /90dayRx retail	No charge	

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)	
More information about prescription drug coverage is available at www.caremark.com	Specialty drugs	Refer to applicable prescription drug cost sharing	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$800 copay / surgery	30% coinsurance (if permitted)	None
	Physician/surgeon fees	No charge	30% coinsurance (if permitted)	None
If you need immediate medical attention	Emergency room care	\$150 copay /visit	\$150 copay /visit	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	\$105 copay /visit	\$105 office visit copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	\$1,500 copay /admission	30% coinsurance (if permitted)	None
	Physician/surgeon fee	No charge	30% coinsurance (if permitted)	None
If you need mental health, behavioral health, or substance use services	Outpatient services	\$105 copay /visit	30% coinsurance (if permitted)	Services for marriage/couples counseling are not covered.
	Inpatient services including adult mental health treatment	\$1,500 copay /admission	30% coinsurance (if permitted)	None
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: No charge	Prenatal care: No charge Postnatal care: No charge (if permitted)	Cost sharing does not apply for preventive services . Depending on the type of services, other cost sharing may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	No charge (if permitted)	
	Childbirth/delivery facility services	\$1,500 copay / admission	30% coinsurance (if permitted)	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	30% coinsurance (if permitted)	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)	
	Rehabilitation services	\$105 copay /visit for occupational therapy \$105 copay /visit for physical therapy \$105 copay /visit for speech therapy	30% coinsurance for occupational therapy (if permitted) 30% coinsurance for physical therapy (if permitted) 30% coinsurance for speech therapy (if permitted)	None
	Habilitation services	\$105 copay /visit for occupational therapy \$105 copay /visit for physical therapy \$105 copay /visit for speech therapy	30% coinsurance for occupational therapy (if permitted) 30% coinsurance for physical therapy (if permitted) 30% coinsurance for speech therapy (if permitted)	
	Skilled nursing care	No charge	30% coinsurance (if permitted)	None
	Durable medical equipment	30% coinsurance	30% coinsurance (if permitted)	None
	Hospice service	No charge	30% coinsurance (if permitted)	180 day maximum applies for all networks. 2 per hospice episode maximum per lifetime for all networks.
If your child needs dental or eye care	Children's eye exam	No charge	No charge (if permitted)	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 .)		
<ul style="list-style-type: none"> Acupuncture (except as specified in plan benefits) Cosmetic surgery (except as specified in plan benefits) 	<ul style="list-style-type: none"> Dental care (except as specified in plan benefits) Infertility treatment Long-term care 	<ul style="list-style-type: none"> Non-emergency care when traveling outside the U.S. 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.)

- Bariatric surgery
- Chiropractic care
- Hearing aids (as required by Minnesota State law)
- Private duty nursing (as required by Minnesota State law)
- 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: Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at 1-877-267-2323, extension 61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit <http://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 Claims Administrator by calling toll-free 1-800-883-2177 or if you are covered under a plan offered by the State Health Plan, a city, county, school district, or Service Coop, you may contact the Department of Health and Human Services Health Insurance team at 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 MNsure/the Marketplace.

Statement of nondiscrimination

Our responsibilities:

We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
 - o Qualified sign language interpreters
 - o Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
 - o Qualified interpreters
 - o Information written in other languages

For language or communication help:

Call 1-800-883-2177 if you need language or other communication help.

If you have questions about our non-discrimination policy:

Contact the Civil Rights Coordinator at 1-844-363-8732 or integrityandcompliance@healthpartners.com.

To file a grievance:

If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, integrityandcompliance@healthpartners.com or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue SW
Washington, DC 20201
1-800-368-1019
1-800-537-7697 (TDD)

Language Access Services:

This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိကညီကျိန်ဒီး, တံကဟ့ၣ်န့ၣ်ကျိန်တံမၤစၢၤကလိတဖၣ်န့ၣ်လိၤ. ကိ: 1-866-251-6744 လၢ TTYအဂီၢ်, ကိ: 711 တက့ၢ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta'e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າພຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສໍາລັບ TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមិន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yánílt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojí éí béésh bee hodíílnih 1-855-902-2583. TTY biniyégo éí 711 jí' béésh bee hodíílnih.

—————*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](#), [copay](#) 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 prenatal care and a hospital delivery)

- The plan's overall [deductible](#) \$3,000
- [Specialist copay](#) \$105
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copays	\$1,000
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,060

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

- The plan's overall [deductible](#) \$3,000
- [Specialist copay](#) \$105
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copays	\$600
Coinsurance	\$100
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$3,720

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

- The plan's overall [deductible](#) \$3,000
- [Specialist copay](#) \$105
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 30%

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:

<i>Cost Sharing</i>	
Deductibles	\$2,400
Copays	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,400

The total patient would pay amount assumes the patient is not using funds from a Flexible Spending Account (FSA), Health Savings Account (HSA), or an integrated Health Reimbursement Account (HRA), including an integrated HRA funded through a Voluntary Employee Beneficiary Association (VEBA-HRA). Account balances may provide you funds to help cover out-of-pocket expenses.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.