

# PEIP Advantage Value Option Plan Cost Level 2

## 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 and Family | Plan Type: Tiered



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](http://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 a PPO provider is available but not used, coverage will be limited to the point-of-service benefits (\$350 Single/\$700 Family deductible, 30% coinsurance).

Important Questions	Answers	Why this Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	<b>\$850</b> medical per individual <a href="#">network</a> <b>\$1,700</b> medical per family <a href="#">network</a> <b>\$350</b> medical per individual <a href="#">out-of-network</a> <b>\$700</b> medical per family <a href="#">out-of-network</a>	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. This <a href="#">plan</a> has an embedded <a href="#">deductible</a> . If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes. Well-child care, prenatal care and <a href="#">network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copay</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	No	You don't have to meet <a href="#">deductibles</a> for specific services.

<b>What is the <a href="#">out-of-pocket limit</a> for this plan?</b>	<p><b>\$2,600</b> medical per individual <a href="#">network</a> and <a href="#">out-of-network</a></p> <p><b>\$5,200</b> medical per family <a href="#">network</a> and <a href="#">out-of-network</a></p> <p><b>\$1,250</b> drugs per individual <a href="#">network</a></p> <p><b>\$2,500</b> drugs per family <a href="#">network</a></p>	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. This <a href="#">plan</a> has an embedded <a href="#">out-of-pocket limit</a> . If you have other family members on this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the <a href="#">out-of-pocket limit</a>?</b>	<a href="#">Premiums</a> , <a href="#">balance-billed</a> charges, and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use an <a href="#">in-network provider</a>?</b>	Yes. See <a href="http://www.healthpartners.com">www.healthpartners.com</a> or call 1-800-883-2177 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as laboratory work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a>?</b>	Yes.	The plan will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have the plan's permission before you see the <a href="#">specialist</a> .



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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury	\$40 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a> (if permitted)	None
	<a href="#">Specialist</a> visit	\$40 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a> (if permitted)	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	No charge (if permitted)	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . Then check what your <a href="#">plan</a> will pay for.
If you have a test	<a href="#">Diagnostic test</a> (x-ray, blood work)	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> (if permitted)	None
	Imaging (CT/PET scans, MRIs)	15% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> (if permitted)	

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)	
<p><b>If you need drugs to treat your illness or condition.</b>  <b>A retail pharmacy is any licensed pharmacy that you can physically enter to obtain a prescription drug. A mail service pharmacy dispenses <a href="#">prescription drugs</a> through the U.S. Mail.</b>            More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a></p>	Preferred generic drug	\$25.00 <a href="#">copay</a> /retail \$50.00 <a href="#">copay</a> /mail service \$50.00 <a href="#">copay</a> /90dayRx retail	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.
	Preferred brand drugs	\$45.00 <a href="#">copay</a> /retail \$90.00 <a href="#">copay</a> /mail service \$90.00 <a href="#">copay</a> /90dayRx retail	Not covered	
	Non-preferred drugs	\$70.00 <a href="#">copay</a> /retail \$140.00 <a href="#">copay</a> /mail service \$140.00 <a href="#">copay</a> /90dayRx retail	Not covered	
	<a href="#">Specialty drugs</a>	Refer to applicable prescription drug <a href="#">cost sharing</a>	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager
<p><b>If you have outpatient surgery</b></p>	Facility fee (e.g., ambulatory surgery center)	\$175 <a href="#">copay</a> /surgery	30% <a href="#">coinsurance</a> (if permitted)	None
	Physician/surgeon fees	No charge	30% <a href="#">coinsurance</a> (if permitted)	None
<p><b>If you need immediate medical attention</b></p>	<a href="#">Emergency room care</a>	\$125 <a href="#">copay</a> /visit	\$125 <a href="#">copay</a> /visit	None
	<a href="#">Emergency medical transportation</a>	10% <a href="#">coinsurance</a>	10% <a href="#">coinsurance</a>	None
	<a href="#">Urgent care</a>	\$40 <a href="#">copay</a> /visit	\$40 <a href="#">copay</a> /visit	None
<p><b>If you have a hospital stay</b></p>	Facility fee (e.g., hospital room)	\$325 <a href="#">copay</a> /admission	30% <a href="#">coinsurance</a> (if permitted)	None
	Physician/surgeon fee	No charge	30% <a href="#">coinsurance</a> (if permitted)	None
<p><b>If you need mental health, behavioral health, or substance use services</b></p>	Outpatient services	\$40 <a href="#">copay</a> /visit	30% <a href="#">coinsurance</a> (if permitted)	Services for marriage/couples counseling are not covered.
	Inpatient services including adult mental health treatment	\$325 <a href="#">copay</a> /admission	30% <a href="#">coinsurance</a> (if permitted)	None
<p><b>If you are pregnant</b></p>	Office visits	Prenatal care: No charge Postnatal care: No charge	Prenatal care: No charge Postnatal care: No charge (if permitted)	<a href="#">Cost sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other

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)	
	Childbirth/delivery professional services	No charge	No charge (if permitted)	<a href="#">cost sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery facility services	\$325 <a href="#">copay</a> /admission	30% <a href="#">coinsurance</a> (if permitted)	
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	10% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> (if permitted)	None
	<a href="#">Rehabilitation services</a>	\$40 <a href="#">copay</a> /visit for occupational therapy \$40 <a href="#">copay</a> /visit for physical therapy \$40 <a href="#">copay</a> /visit for speech therapy	30% <a href="#">coinsurance</a> for occupational therapy (if permitted) 30% <a href="#">coinsurance</a> for physical therapy (if permitted) 30% <a href="#">coinsurance</a> for speech therapy (if permitted)	None
	<a href="#">Habilitation services</a>	\$40 <a href="#">copay</a> /visit for occupational therapy \$40 <a href="#">copay</a> /visit for physical therapy \$40 <a href="#">copay</a> /visit for speech therapy	30% <a href="#">coinsurance</a> for occupational therapy (if permitted) 30% <a href="#">coinsurance</a> for physical therapy (if permitted) 30% <a href="#">coinsurance</a> for speech therapy (if permitted)	
	<a href="#">Skilled nursing care</a>	No charge	30% <a href="#">coinsurance</a> (if permitted)	
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a>	30% <a href="#">coinsurance</a> (if permitted)	None
	<a href="#">Hospice service</a>	No charge	30% <a href="#">coinsurance</a> (if permitted)	180 day maximum applies for all networks. 2 per hospice episode maximum per lifetime for all networks.
	<b>If your child needs dental or eye care</b>	Children's eye exam	No charge	No charge (if permitted)
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](#).)

- Acupuncture (except as specified in [plan](#) benefits)
- Dental care (except as specified in [plan](#) benefits)
- Non-emergency care when traveling outside the U.S.
- Cosmetic surgery (except as specified in [plan](#) benefits)
- Infertility treatment
- Routine foot care
- Long-term 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
- Private duty nursing (as required by Minnesota State Law)
- Chiropractic care
- Routine eye care (adult)
- Hearing aids (as required by Minnesota State Law)

**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](http://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:
  - Qualified sign language interpreters
  - 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:
  - 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](mailto: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](mailto: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](http://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.

နမ့်ကတိကညီကိုင်ဒီး, တံကဟ့ဒ်နကိုင်တံမစးကလိတဖ်န့ဒ်လီ. ကိ: 1-866-251-6744 လာ TTYအဂီ, ကိ: 711 တက့.

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 biniiyégo 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](#) \$850
- [Specialist copay](#) \$40
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 15%

**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*

<a href="#">Deductibles</a>	\$850
<a href="#">Copays</a>	\$300
<a href="#">Coinsurance</a>	\$100

**What isn't covered**

Limits or exclusions	\$60
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**The total Peg would pay is** \$1,310

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

- The plan's overall [deductible](#) \$850
- [Specialist copay](#) \$40
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 15%

**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*

<a href="#">Deductibles</a>	\$850
<a href="#">Copays</a>	\$800
<a href="#">Coinsurance</a>	\$100

**What isn't covered**

Limits or exclusions	\$20
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**The total Joe would pay is** \$1,770

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

- The plan's overall [deductible](#) \$850
- [Specialist copay](#) \$40
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 15%

**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*

<a href="#">Deductibles</a>	\$850
<a href="#">Copays</a>	\$400
<a href="#">Coinsurance</a>	\$80

**What isn't covered**

Limits or exclusions	\$0
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**The total Mia would pay is** \$1,330

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.