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 01/01/2025
Coverage for: Individual/Family | Plan Type: PPO

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, copayment, 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** This plan does not cover services with out-of-network providers, except for Emergency and Urgent Care. All services must be coordinated with the Primary Care Clinic (PCC).

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$850 individual / $1,700 family medical in-network	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. This plan has an embedded deductible. 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. Well child care, prenatal care and in-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 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?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$2,600 individual medical in-network $5,200 family medical in-network $1,250 individual drug in-network $2,500 family drug in-network	The out-of-pocket limit is the most you could pay in a year for covered services. This plan has an embedded out-of-pocket limit. If you have other family members on 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?	Premiums, balance-billing 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.

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 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 in-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?	Yes	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

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
		In-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	$40 copay/office visit	Not covered	None
	Specialist visit	$40 copay/office visit	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	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)	15% coinsurance	Not covered	May require prior authorization.
	Imaging (CT/PET scans, MRIs)	15% coinsurance	Not covered	
If you need drugs to treat your illness or condition. More information about prescription drug coverage is available at www.caremark.com	Preferred generic drugs	$25 copay/prescription (retail) $50 copay/prescription (mail service) $50 copay/prescription (90dayRx retail)	Not covered	For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager. May require prior authorization.
	Preferred brand drugs	$45 copay/prescription (retail) $90 copay/prescription (mail service) $90 copay/prescription (90dayRx retail)	Not covered	

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Non-preferred drugs	$70 copay/prescription (retail) $140 copay/prescription (mail service) $140 copay/prescription (90dayRx retail)	Not covered	
	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)	$175 copay/surgery	Not covered	May require prior authorization.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	$250 copay/visit	$250 copay/visit	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	$40 copay/visit	$40 copay/visit	None
If you have a hospital stay	Facility fee (e.g., hospital room)	$325 copay/admission	Not covered	None
	Physician/surgeon fee	No charge	Not covered	None
If you need mental health, behavioral health, or substance use services	Outpatient services	No charge	Not covered	Services for marriage/couples counseling are not covered. May require prior authorization.
	Inpatient services including adult mental health treatment	$325 copay/admission	Not covered	
If you are pregnant	Office visits	Prenatal care: No charge Postnatal care: No charge	Not covered	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 (e.g., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$325 copay/admission	Not covered	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	May require prior authorization.

Common Medical Event	Services You May Need	What you Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	$40 copay/visit for occupational therapy $40 copay/visit for physical therapy $40 copay/visit for speech therapy	Not covered	May require prior authorization.
	Habilitation services	$40 copay/visit for occupational therapy $40 copay/visit for physical therapy $40 copay/visit for speech therapy	Not covered	
	Skilled nursing care	No charge	Not covered	No deductible applies in network May require prior authorization.
	Durable medical equipment	20% coinsurance	Not covered	May require prior authorization.
	Hospice service	No charge	Not covered	Coverage is limited to a maximum of 180 visit(s) per calendar year all providers combined 2 per hospice episode maximum per lifetime for all networks. No deductible applies in-network
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	Not covered	Not covered	No coverage for these services
	Children's dental check-up	Not covered	Not covered	No coverage for these services

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.)

- Cosmetic surgery
- Dental care (Adult) (and children)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- 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.)		
• Acupuncture	• Chiropractic care	• Infertility treatment
• Bariatric surgery	• Hearing aids	• 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.

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.

Notice of Nondiscrimination Practices
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
  - Information written in other languages

For Language or Communication Help: Call 1-800-883-2177 if you need language or other communication help. (TTY: 711)
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 https://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, 800-537-7697 (TDD)

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, copayment 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 copayment	**$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	
Deductibles	$850
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
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 copayment	**$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	
Deductibles	$850
Copayments	$900
Coinsurance	$10
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,780**

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

The plan's overall deductible	**$850**
Specialist copayment	**$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	
Deductibles	$850
Copayments	$500
Coinsurance	$80
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,430**

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