Eastern Carver County Schools

2021-2022
EMPLOYEE BENEFITS

YOUR GUIDE.

YOUR ADVOCATE.

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This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.

Benefits Overview

Eastern Carver County Schools is proud to offer a comprehensive benefits package to eligible employees. We have briefly summarized the benefits available in this booklet. The full plan booklets, which give you more detailed information about each of these programs, are located on the intranet (The Insider) for your review as well.

You share the costs of some benefits (medical and dental), and based on your contract, Eastern Carver County Schools provides other benefits at little or no cost to you (Life, Long-Term Disability). In addition, there are voluntary benefits with reasonable group rates that you can purchase through Eastern Carver County Schools payroll deductions.

Benefit Plans Offered

- Medical
- Health Savings Account (HSA)
- Flexible Spending Accounts (FSA)
- Dental
- Life Insurance/AD&D
- Voluntary Life and AD&D
- Long-Term Disability
- Employee Assistance Program (EAP)

Eligibility

All employees working 30 hours per week and all retirees and early retirees are eligible. Employees must enroll themselves and any eligible dependents within 30 days of the date they first become eligible. The employee must enroll a newly acquired dependent (such as a new spouse) within 30 days of when the new dependent is first acquired.

Late Enrollment: if you do not enroll yourself or any eligible dependents within 30 days of the date that you or your dependents first become eligible, you may enroll yourself and any eligible dependents during the annual open enrollment period.

There may be additional situations when you are eligible to enroll yourself and any eligible dependents after the first 30 days of eligibility. If you have questions about the items included in this summary, please contact Human Resources.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact Human Resources within 30 days.

Medical Benefits

Administered by HealthPartners

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with an excellent medical plan through Eastern Carver County Schools.

Employees can access, view and print their member ID card anytime, from any computer by signing into www.healthpartners.com and clicking on the "Member ID card" link. This is a fast and convenient way to show proof of health care coverage if you don't have your health insurance card readily available.

Virtuwell

Virtuwell is HealthPartners' online healthcare tool that can treat more than 60 common conditions. Simply go online to www.virtuwell.com and complete a short questionnaire. A Nurse Practitioner will then contact you with your treatment plan, and if necessary will send a prescription to the pharmacy of your choice. This is available 24/7, 365 days a year and only costs $59 per visit. Virtuwell is now integrated into the billing process whereby claims are applied to the deductible and reimbursable through the employee's HSA or FSA. Save a trip to Urgent Care and use Virtuwell instead!

Summary of Benefits and Coverage

Employees may view the Summary of Benefit and Coverage (SBC) for each of the three HealthPartners health insurance plan designs offered through Eastern Carver County Schools starting on page 17 of this document. You may also access the SBCs on the district intranet (The Insider), or by requesting a paper copy from Human Resources.

Network Options

Open Access

The Open Access network is the largest and includes both the Mayo Clinic Rochester location as well as Mayo Clinic Health Systems locations. Approximately 98% of physicians and 100% of hospitals in MN participate in this network.

Achieve

The Achieve network includes HealthPartners and Park Nicollet Clinics, Ridgeview Area Clinics, several independent clinics, and many area hospitals.

You can search providers in your network by logging in to your myHealthPartners account at www.healthpartners.com/public/login/ or by calling Member Services at 952.883.5000 or 800.883.2177.

Medical Plan Summaries

Administered by HealthPartners

Carrier	HealthPartners		
Plan	**$40 Copay Plan**	**$1,500 Deductible Plan**	**$2,800 HDHP.HSA Plan**
IN-NETWORK PLAN DESIGN FEATURES			
Lifetime Maximum	Unlimited	Unlimited	Unlimited
Annual Maximum	N/A	N/A	N/A
Deductible Plan Year (July 1 - June 30)	$200 / person $400 / family	$1,500 / person $3,000 / family	$2,800 / person $5,600 / family
Coinsurance	90 / 10%	80 / 20%	100%
Medical Out-of-Pocket Maximum	$2,400 / person $4,800 / family	$2,400 / person $4,800 / family	$2,800 / person $5,600 / family
MEDICAL			
Preventive Care	100% coverage	100% coverage	100% coverage
Office Visit and Urgent Care (office based)	$40 copay	You pay 20% after the deductible	100% after deductible
Convenience / Retail Care Clinic	$20 copay	You pay 20% after the deductible	100% after deductible
Online Care (Virtuwell)	First three visits are no charge; $20 copay thereafter	First three visits are no charge; 20% after deductible thereafter	100% after deductible
Lab, Pathology, X-ray	100% coverage	You pay 20% after the deductible	100% after deductible
Inpatient and Outpatient Hospitalization	90/10%	You pay 20% after the deductible	100% after deductible
Emergency Room Facility	$100 copay	You pay 20% after the deductible	100% after deductible
PRESCRIPTION DRUGS (RX)	**Preferred Rx Formulary**		
Pharmacy Out-of-Pocket Maximum	$500 / person	$750 / person $1,000 / family	Included in Medical Out-of- Pocket Maximum
Retail Pharmacy	Generic: $20 copay Brand: $29.97 copay Non-Formulary: Not covered	Generic: $20 copay Brand: $29.97 copay Non-Formulary: Not covered	100% after deductible
Specialty Pharmacy	You pay 20% capped at $200 per script per month	Generic: $20 copay Brand: $29.97 copay Non-Formulary: Not covered	100% after deductible
Mail Order Pharmacy	Generic: $40 copay Brand: $59.94 copay Non-Formulary: Not covered	Generic: $40 copay Brand: $59.94 copay Non-Formulary: Not covered	100% after deductible
MONTHLY PREMIUMS	OPEN ACCESS		
Single	$725.76	$570.68	$534.30
Single + 1	$1,451.52	$1,141.36	$1,068.58
Family	$1,802.58	$1,417.42	$1,327.08
MONTHLY PREMIUMS	ACHIEVE		
Single	$688.74	$541.48	$507.06
Single + 1	$1,377.46	$1,083.16	$1,014.08
Family	$1,710.62	$1,345.12	$1,259.36

This analysis is an outline of the coverage proposed by the carrier(s) based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for more details. Policy forms for your reference will be made available upon request.

Health Savings Account (HSA)

Administered by HSA Bank

An HSA, or health savings account, is a unique tax-advantaged account that can be used to pay for current or future healthcare expenses. When combined with a high-deductible health plan, it offers savings and tax advantages that a traditional health plan can't duplicate. This account is owned by you, is in your name, and goes with you even if you leave employment with Eastern Carver County Schools. You are also able to open a self-directed investment account through our administrator, HSA Bank, once you have met the minimum threshold required in your HSA. More information regarding investing with HSA Bank can be found on the district intranet (the Insider).

HSA Eligibility – Who is Eligible?

You must be enrolled in a qualified High Deductible Health Plan (HDHP). Eastern Carver's HSA plan meets these qualifications. You also cannot be enrolled in any of the following disqualifying coverages:

- Covered by other non-qualified HDHP including traditional health plans, FSA, HRA, or spouse's health and/or FSA plans
- Enrolled in Medicare or Medicaid
- Claimed as a dependent on another's tax return
- Covered under TRICARE

HSA Contributions - How much can I put in?

You have the options to put money in your HSA by contributing pre-tax dollars from your paycheck. For 2021, the maximum contributions* into an HSA, as established by the IRS, are:

- $3,600 single coverage
- $7,200 family coverage (including employee+1 coverage).

Employees age 55 and older can make additional catch-up contributions of up to $1,000 each year until they enroll in Medicare.

*Maximums include both Employer contributions and Employee elected contributions. Your HSA contributions are deducted from your paycheck before taxes are withheld, so you save on taxes and have more disposable income.

Example of the Tax Savings Offered through the Health Savings Account

Below is a brief example of how utilizing an HSA can help you save money on taxes each year. Example assumes: $40,000 annual salary, $2,800 out-of-pocket medical and dental expenses.

	Without HSA	With HSA
Gross Pay	$40,000	$40,000
HSA Contributions	- $	- $2,800
Taxable Income	$40,000	$37,200
Taxes (Fed, State, FICA)	- $12,000	- $11,160
Out-of Pocket Expenses	- $2,800	- $2,800
Reimbursements from HSA	+$	+ $2,800
Net Annual Income	$25,200	$26,040

*This example is for illustrative purposes only and should not be considered tax advice.

HSA Withdrawals

As long as you use your HSA dollars on qualified expenses, all withdrawals are tax-free! You can reimburse yourselves for expenses incurred for yourself, as well as your spouse and/or tax dependents, even if they aren't enrolled in the medical here at Eastern Carver County Schools.

HSA Bank will not ask you to submit proof of eligible expenses at the time of withdrawal. However, you should retain your receipts and explanation of benefits in your personal income tax files in the event you are audited. At the end of the year, HSA Bank will provide you with a Form 8889 to file with your income taxes.

Any unused funds in your HSA will rollover from year to year - there is not a use-it-or-lose-it provision with an HSA. There is also no maximum balance in an HSA, which allows you to set aside money in healthier years to help pay for any future medical expenses you may incur.

Flexible Spending Accounts (FSAs) – Health and/or Dependent Care Reimbursement

Administered by PlanSource

You can save money on your healthcare and/or dependent day care expenses with an FSA. You set aside funds each pay period on a pre-tax basis and use them tax-free for qualified expenses. You pay no taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

The Flexible Spending Account allows you to set aside "pre-tax" dollars to pay for:

- Dependent Care Expenses (up to a maximum of $5,000 per year)
- Health Care Reimbursement (up to a maximum of $2,750 per year)

Here's How an FSA Works

1. You decide the annual amount (up to the above listed maximum for each account) you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare / elder care expenses.
2. Your contributions are deducted from each paycheck before taxes, and deposited into your FSA.
3. You can pay with the Healthcare FSA debit card for eligible healthcare expenses. For dependent care, you pay for eligible expenses when incurred, and then file the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.

NOTE: If you participate in the HSA you may NOT participate in the Health Care Reimbursement Plan (FSA). You may participate in the Dependent Care Reimbursement Plan regardless of HSA or FSA account.

Voluntary Dental Benefits

Administered by Delta Dental

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Eastern Carver County Schools' dental benefit plan.

Delta Dental of Minnesota is our plan administrator. Please refer to the schedule below for a summary of the benefits. After you have satisfied the deductible (if applicable) your dental plan pays the following percentages of the treatment costs, up to a maximum fee per procedure. The maximum fee allowed by Delta is different for participating dentists and non-participating dentists. If you see a non-participating dentist your out-of-pocket expenses may increase.

Benefit Maximums

The Plan pays up to a maximum of $1,500 for each covered person per plan year (July 1- June 30) subject to the coverage percentages identified below. Please Note: Any amount the Plan pays for Diagnostic and Preventive Services goes towards the Annual Maximum, even though there is no cost to you for those services.

Deductible

There is a $25 deductible per Covered Person each Plan Year not to exceed 3 times that amount ($75) per Family Unit. The deductible does not apply to Diagnostic and Preventive Services.

The following is an overview of your Delta Dental coverage. For exact coverage terms and conditions, consult your plan materials.

Voluntary Dental Plan through Delta Dental		
	Delta PPO & Delta Premier Networks	**Non-Participating* Care from an out-of-network provider**
Annual Maximum (July 1 - June 30)	Plan pays $1,500 per Plan year	Plan pays $1,500 per Plan year
Annual Deductible (July 1 - June 30) Applies to Basic Care, Special Care & Prosthetics	$25 / person $75 / family per plan year	$25 / person $75 / family per plan year
PREVENTIVE / DIAGNOSTIC CARE		
Teeth cleaning, exams, dental x-rays and fluoride treatments	You pay nothing	You pay nothing
Sealants	You pay nothing	You pay nothing
BASIC I SERVICES		
Fillings (amalgam and anterior composite)	You pay 20%	You pay 20% of maximum allowable fee
Posterior composite (white fillings)		
Simple extraction		
Non-surgical periodontics		
Endodontics (root canal therapy)		
BASIC II SERVICES		
Surgical periodontics	You pay 20%	You pay 20% of maximum allowable fee*
Complex Oral Surgery		
SPECIAL CARE		
Restorative crowns and onlays	You pay 20%	You pay 20% of maximum allowable fee*
PROSTHETICS		
Bridges, dentures, and partial dentures	You pay 50%	You pay 50% of maximum allowable fee*

*If dental services are received from a non-participating dentist, you will be responsible for paying the difference between the maximum allowable amount and what the dentist charges.

This analysis is an outline of the coverage proposed by the carrier(s) based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for more details. Policy forms for your reference will be made available upon request.

2021-2022 Dental Rates

Monthly 2021-2022 Delta Dental Premiums	
Single	$38.22
Single + 1	$76.46
Family	$125.62

How do I find a Participating Dentist?

Dental Dental's in-network dentists are called PPO & Premier dentists. PPO dentists are providers that Delta Dental has contracted with to provide you the deepest discounts on services, thereby helping your Annual Maximum to go further. Premier dentists are also in-network, just with different contracted rates than PPO dentists.

To find an in-network dentist nearest you, visit www.deltadentalmn.org, click on "Find Dentist", then under Select Your Network choose the "PPO & Premier Networks" option from the drop-down menu. Then, under Pick Your Location, enter your location and search. You may also call Customer Service locally at 651.406.5916 or toll-free at 800.553.9536.

Life and Accidental Death & Dismemberment Insurance

Insured by The Standard

Life insurance provides financial security for the people who depend on you. At little or no cost to you, this benefit can provide your beneficiaries with a lump-sum payment if you die while employed by Eastern Carver County Schools.

Basic Group Term Life and Accidental Death & Dismemberment Insurance

- Accidental Death and Dismemberment (AD&D) insurance would pay an additional benefit, up to the amount of your Life Benefit, if you suffer a covered loss due to an Accidental Injury.
- Accelerated Benefits help offset expenses at a critical time. You may collect a portion of your benefits during your lifetime if you become terminally ill.
- If you leave Eastern Carver County Schools, you may be able to convert your group life coverage to individual Life insurance. Please contact Human Resources for details.
- See the full details in the Life Certificate of Coverage from The Standard.

Voluntary Life Insurance

Insured by The Standard

You may purchase life insurance in addition to the Group Life insurance coverage. You may also purchase life insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage, up to the Guaranteed Issue amount listed below, without answering medical questions if you enroll when you are first eligible (upon hire).

For you: An amount between $10,000 and $150,000 in increments of $10,000. Guaranteed Issue Amount is $100,000.
For your spouse: An amount between $5,000 and $75,000, in increments of $5,000. Guaranteed Issue Amount is $50,000.
For your dependent child(ren): An amount of $5,000 or $10,000 for each eligible child from birth to 26 years.

How to Enroll

If you select to enroll in Voluntary Life Insurance, above the guaranteed issue amount, an Evidence of Insurability form is required. You will receive one from your employer.

Optional Life Rates		
Age	**Employee and Spouse**	**Child(ren)**
	Monthly Cost per $1,000 of coverage	**Monthly Cost**
Under 30	$0.050	All Eligible Children: $0.180 per $1,000
30–34	$0.060	
35–39	$0.080	
40–44	$0.130	
45–49	$0.210	
50–54	$0.340	
55–59	$0.540	
60–64	$0.840	
65–69	$1.510	
70–74	$2.420	
75–99	$3.830	

* Employee and Spouse rates based on employee's age as of July 1st.

For Complete Plan Details

This information is intended to provide an overview of the benefits available from your employer and is not a complete description of plan provisions. You can view full plan details on the district intranet (the Insider) or by requesting a copy from Human Resources.

Receipt of this information does not certify eligibility for benefits under this plan. For complete plan designs, you may request a copy of the Life Certificate of Coverage from The Standard from your employer.

Long-Term Disability Insurance

Insured by The Standard

Meeting your basic living expenses can be a real challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for your most valuable asset—your ability to earn an income. Long-Term Disability (LTD) provides income replacement benefits for you in the event you are unable to work due to an accident or sickness. Please contact your HR department for full details.

Benefit Amount:	$66^{2/3}$% for all employee groups
Elimination Period:	60 days for all employee groups
Maximum Benefit Period:	To age 65 (in most cases*)
Definition of Disability:	Unable to perform one or more of the material duties of your Own Occupation earning less than 80% of your indexed predisability earnings
Own Occupation Period:	24 months following the end of the elimination period
Survivor Benefit:	3 times the Lifetime Maximum Benefit
Limitations and Exclusions:	Benefits for Mental and Nervous and Substance Abuse claims are limited to 24 months unless hospital confined

*If you become disabled at age 63 or older, your maximum benefit period is determined by a set schedule. If this applies to you, please refer to the full policy for additional details.

Employee Assistance Program

Administered by Vital WorkLife

A resource where employees go for help with problems ranging from depression, to ongoing or situational stress and anxiety, to concerns about everything from family and relationship issues to financial and legal problems, to coping with chemical dependency, to finding the right eldercare or childcare resources.

Eastern Carver County Schools is providing this complimentary resource to you and your family members.

Whatever the issue confronting you or your family members, you are eligible for free and confidential professional support services from VITAL WorkLife —24 hours a day, 365 days a year — to help you.

- Resolve marital and relationship troubles
- Relieve depression, stress and anxiety
- Recover from drug and alcohol abuse
- Overcome legal and financial problems
- Create a plan for educational success
- Legal Consultation. Including family issues, Property and Contracts, Personal Injury and much more.
- Find child care/elderly care / adopting agencies

Call Vital WorkLife anytime, day or night

800.383.1908

www.VITALWorkLife.com

Username: eccs

Password: member

THRIVE! Program

THRIVE's Mission

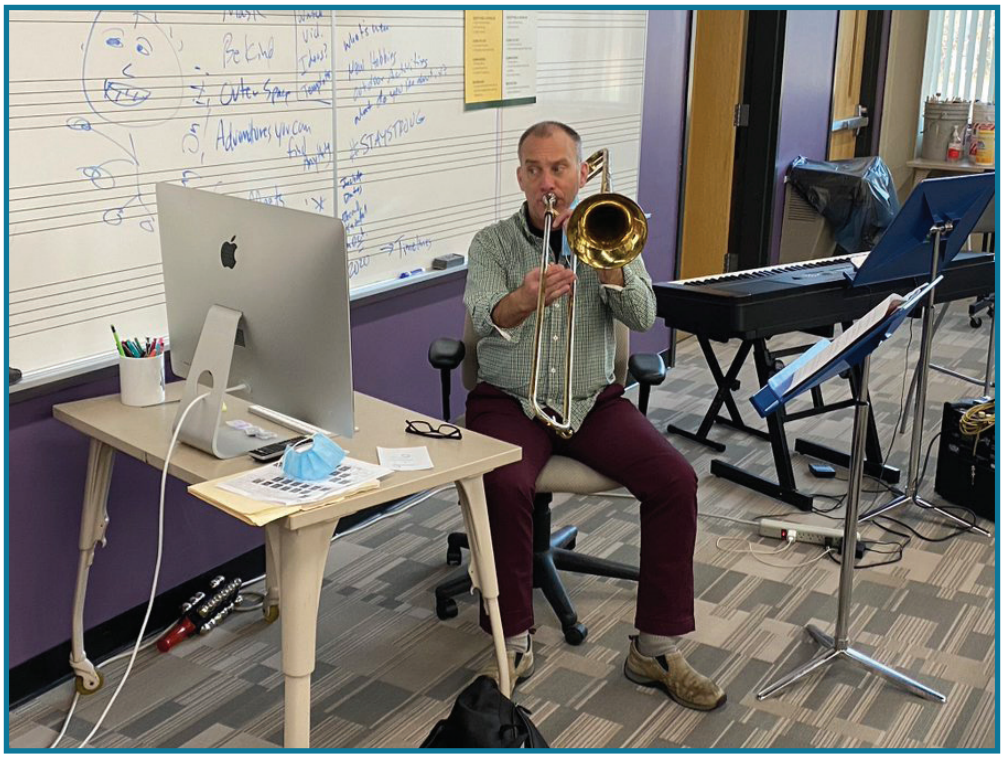
Together, building a culture of health in Eastern Carver County Schools

THRIVE's Vision

To create and sustain healthy learning and work environments in Eastern Carver County Schools. Guided by best practice resources, we will build the foundation for life-long learning by improving the health and wellbeing of staff and students.

Goals of THRIVE

- Gain leadership support to help promote and participate in wellbeing activities
- Highlight current resources in each area of wellbeing
- Communicate THRIVE's mission, goals and structure
- Staff program evaluation
- Promote and understand the 5 areas of wellbeing and Employee Assistance Program
- Each school work on wellbeing initiatives that benefit their population (i.e. School garden, active classroom, etc.)



Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local Human Resources department.

Benefit	Administrator	Phone	Website/Email
Medical	HealthPartners	952.883.5000	www.healthpartners.com
Dental	Delta Dental	800.328.1188	www.deltadentalmn.org
Life and AD&D Insurance	The Standard	888.937.4783	www.standard.com
Voluntary Life and AD&D Insurance	The Standard	888.937.4783	www.standard.com
Long-Term Disability	The Standard	888.937.4783	www.standard.com
Employee Assistance Program	VITAL Work Life	800.383.1908	www.VITALworklife.com
Flexible Spending Accounts	PlanSource	866.546.9134	www.plansource.com
Health Savings Account	HSA Bank	800.657.6246	www.hsabank.com
ECCS Human Resources	Laurie Zebell	952.556.6253	ZebellL@district112.org

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Notification of Possible Federal Public Service Loan Forgiveness Eligibility 53

Statement of Non-Discrimination 54

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.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $200 Individual, $400 Family Out-of-network: $400 Individual, $800 Family	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.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network medical: $2,400 Individual, $4,800 Family Out-of-network medical: $4,800 Individual, $9,600 Family Pharmacy: $500 Individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	Pharmacy copays, pharmacy coinsurance, 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.
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	Office Visit: $40 copay* Convenience Care: $20 copay* virtuwell: No charge for the first three visits and $20 copay* thereafter	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance virtuwell: Not covered	None
	Specialist visit	$40 copay*	25% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	25% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: $20 copay* at retail, $40 copay* at mail Non-formulary: Not covered	Formulary: 25% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	$29.97 copay* at retail, $59.94 copay* at mail		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	20% coinsurance*	25% coinsurance at retail, mail not covered	$200 maximum copay per prescription per month
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	None
	Physician/surgeon fees	10% coinsurance	25% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay*	$100 copay*	Out-of-network services apply to the in-network deductible

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)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$40 copay*	$40 copay*	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	None
	Physician/surgeon fees	10% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$40 copay*	25% coinsurance	None
	Inpatient services	10% coinsurance	25% coinsurance	None
If you are pregnant	Office visits	No charge	No charge	None
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	None
If you need help recovering or have other special health needs	Home health care	Therapies: $40 copay* IV: No charge	25% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	$40 copay*	25% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	$40 copay*	Not covered	None
	Skilled nursing care	10% coinsurance	25% coinsurance	120 day maximum
	Durable medical equipment	20% coinsurance	25% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	10% coinsurance*	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	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.)

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

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Does this plan provide Minimum Essential Coverage? **Yes**.

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Does this plan meet Minimum Value Standards? **Yes**.

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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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$200
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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

The plan's overall deductible	$200
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

The plan's overall deductible	$200
Specialist copay	$40
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$200
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $200 Individual, $400 Family Out-of-network: $400 Individual, $800 Family	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.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network medical: $2,400 Individual, $4,800 Family Out-of-network medical: $4,800 Individual, $9,600 Family Pharmacy: $500 Individual	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	Pharmacy copays, pharmacy coinsurance, 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.
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	Office Visit: $40 copay* Convenience Care: $20 copay* virtuwell: No charge for the first three visits and $20 copay* thereafter	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance virtuwell: Not covered	None
	Specialist visit	$40 copay*	25% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	25% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: $20 copay* at retail, $40 copay* at mail Non-formulary: Not covered	Formulary: 25% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	$29.97 copay* at retail, $59.94 copay* at mail		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	20% coinsurance*	25% coinsurance at retail, mail not covered	$200 maximum copay per prescription per month
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	25% coinsurance	None
	Physician/surgeon fees	10% coinsurance	25% coinsurance	None
If you need immediate medical attention	Emergency room care	$100 copay*	$100 copay*	Out-of-network services apply to the in-network deductible

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)	
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$40 copay*	$40 copay*	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	25% coinsurance	None
	Physician/surgeon fees	10% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$40 copay*	25% coinsurance	None
	Inpatient services	10% coinsurance	25% coinsurance	None
If you are pregnant	Office visits	No charge	No charge	None
	Childbirth/delivery professional services	10% coinsurance	25% coinsurance	None
	Childbirth/delivery facility services	10% coinsurance	25% coinsurance	None
If you need help recovering or have other special health needs	Home health care	Therapies: $40 copay* IV: No charge	25% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	$40 copay*	25% coinsurance	Out-of-network: 20 visit limit/year
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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$200**
- **Specialist copay** **$40**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$200
Copayments	$10
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,170**

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

- **The plan's overall deductible** **$200**
- **Specialist copay** **$40**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$200
Copayments	$900
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,220**

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

- **The plan's overall deductible** **$200**
- **Specialist copay** **$40**
- **Hospital (facility) coinsurance** **10%**
- **Other coinsurance** **10%**

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	$200
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

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.
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Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual, $3,000 Family Out-of-network: $3,000 Individual, $6,000 Family	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.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network medical: $2,400 Individual, $4,800 Family Out-of-network medical: $4,800 Individual, $9,600 Family Pharmacy: $750 Individual, $1,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	Pharmacy copays, pharmacy coinsurance, 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.
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

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Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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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 or illness	Office Visit: 20% coinsurance Convenience Care: 20% coinsurance virtuwell: No charge for the first three visits and 20% coinsurance thereafter	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance virtuwell: Not covered	None
	Specialist visit	20% coinsurance	25% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: $20 copay* at retail, $40 copay* at mail Non-formulary: Not covered	Formulary: 25% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	$29.97 copay* at retail, $59.94 copay* at mail		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	$29.97 copay*	25% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	25% coinsurance	None
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		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
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	Urgent care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	None
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If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% coinsurance	25% coinsurance	None
	Inpatient services	20% coinsurance	25% coinsurance	None
If you are pregnant	Office visits	No charge	No charge	None
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	None
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If your child needs dental or eye care	Children's eye exam	No charge	No charge	None
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Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,090**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
HealthPartners:$1,500 Ded Achieve

Coverage Period: 07/01/2021 - 06/30/2022
Coverage for: All Coverage Levels | **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, 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.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual, $3,000 Family Out-of-network: $3,000 Individual, $6,000 Family	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.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network medical: $2,400 Individual, $4,800 Family Out-of-network medical: $4,800 Individual, $9,600 Family Pharmacy: $750 Individual, $1,000 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	Pharmacy copays, pharmacy coinsurance, 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.
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.

Important Questions	Answers	Why This Matters:
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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
		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	Office Visit: 20% coinsurance Convenience Care: 20% coinsurance virtuwell: No charge for the first three visits and 20% coinsurance thereafter	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance virtuwell: Not covered	None
	Specialist visit	20% coinsurance	25% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	25% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	25% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: $20 copay* at retail, $40 copay* at mail Non-formulary: Not covered	Formulary: 25% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	$29.97 copay* at retail, $59.94 copay* at mail		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	$29.97 copay*	25% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	25% coinsurance	None
	Physician/surgeon fees	20% coinsurance	25% coinsurance	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)	
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	20% coinsurance	20% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	25% coinsurance	None
	Physician/surgeon fees	20% coinsurance	25% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% coinsurance	25% coinsurance	None
	Inpatient services	20% coinsurance	25% coinsurance	None
If you are pregnant	Office visits	No charge	No charge	None
	Childbirth/delivery professional services	20% coinsurance	25% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	25% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	25% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	20% coinsurance	25% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	20% coinsurance	25% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	20% coinsurance	25% coinsurance	120 day maximum
	Durable medical equipment	20% coinsurance	25% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	20% coinsurance	25% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	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.)

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

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,460**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$500
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,090**

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

The plan's overall deductible	$1,500
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

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	$1,500
Copayments	$10
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,810**

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.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,800 Individual, $5,600 Family Out-of-network: $5,600 Individual, $11,200 Family	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.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network: $2,800 Individual, $5,600 Family Out-of-network: $11,200 Individual, $22,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	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.
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 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?	No.	You can see the specialist you choose without a referral.

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
		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	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Office Visit: 40% coinsurance Convenience Care: 40% coinsurance virtuwell: Not covered	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance for immunizations, No charge for well child, 40% coinsurance for preventive care, 40% coinsurance for other services	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: 0% coinsurance Non-formulary: Not covered	Formulary: 40% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	0% coinsurance	40% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible

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)	
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	Prenatal: No charge Postnatal: 40% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	40% coinsurance	120 day maximum
	Durable medical equipment	0% coinsurance	40% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	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.)

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

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,800
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	$2,800
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

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

The plan's overall deductible	$2,800
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
HealthPartners:$2800 HSA Achieve

Coverage Period: 07/01/2021 - 06/30/2022
Coverage for: All Coverage Levels | **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, 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.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,800 Individual, $5,600 Family Out-of-network: $5,600 Individual, $11,200 Family	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.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to 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?	In-network: $2,800 Individual, $5,600 Family Out-of-network: $11,200 Individual, $22,400 Family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in 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?	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.
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 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?	No.	You can see the specialist you choose without a referral.

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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
		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	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Office Visit: 40% coinsurance Convenience Care: 40% coinsurance virtuwell: Not covered	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance for immunizations, No charge for well child, 40% coinsurance for preventive care, 40% coinsurance for other services	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: 0% coinsurance Non-formulary: Not covered	Formulary: 40% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	Not covered		
	Specialty drugs	0% coinsurance	40% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible

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)	
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	Prenatal: No charge Postnatal: 40% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	40% coinsurance	120 day maximum
	Durable medical equipment	0% coinsurance	40% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	No charge	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.)

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

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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$2,800
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,860**

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

The plan's overall deductible	$2,800
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,820**

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

The plan's overall deductible	$2,800
Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

Important Notice from EASTERN CARVER COUNTY SCHOOLS About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with **EASTERN CARVER COUNTY SCHOOLS** and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. EASTERN CARVER COUNTY SCHOOLS has determined that the prescription drug coverage offered by the Company plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current **EASTERN CARVER COUNTY SCHOOLS** coverage will not be affected. Your current coverage will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current **EASTERN CARVER COUNTY SCHOOLS** coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with **EASTERN CARVER COUNTY SCHOOLS** and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **EASTERN CARVER COUNTY SCHOOLS** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For More Information About Medicare Prescription Drug Coverage:

- Visit www.medicare.gov.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1.800.MEDICARE (1.800.633.4227). TTY users should call 1.877.486.2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	7/1/2021
Name of Entity/Sender:	Eastern Carver County Schools
Contact Position/Office:	Human Resources
Address:	11 Peavey Road, Chaska MN 55318
Phone Number:	952.556.6253

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are **not** currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 877.KIDS.NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 866.444.EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your state for more information on eligibility.

ALABAMA – Medicaid
http://myalhipp.com 855.692.5447
ALASKA – Medicaid
The AK Health Insurance Premium Payment Program http://myakhipp.com/ | 866.251.4861 CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx
ARKANSAS – Medicaid
http://myarhipp.com 855.MyARHIPP (855.692.7447)
CALIFORNIA – Medicaid
Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp 916.445.8322 | Email: hipp@dhcs.ca.gov
COLORADO – Medicaid and CHIP
Health First Colorado (Colorado's Medicaid Program) https://www.healthfirstcolorado.com Member Contact Center: 800.221.3943 | State Relay 711 Child Health Plan Plus (CHP+) https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Customer Service: 800.359.1991 | State Relay 711 Health Insurance Buy-In Program (HIBI) https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 855.692.6442
FLORIDA – Medicaid
www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html 877.357.3268
GEORGIA – Medicaid
https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp 678.564.1162, ext. 2131

INDIANA – Medicaid
Healthy Indiana Plan for low-income adults 19-64 http://www.in.gov/fssa/hip/ | 877.438.4479 All other Medicaid https://www.in.gov/medicaid/ | 800.457.4584
IOWA – Medicaid and CHIP (Hawki)
Medicaid: https://dhs.iowa.gov/ime/members | 800.338.8366 Hawki: http://dhs.iowa.gov/Hawki | 800.257.8563 HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp | 888.346.9562
KANSAS – Medicaid
https://www.kancare.ks.gov/ 800.792.4884
KENTUCKY – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx 855.459.6328 | KIHIPP.PROGRAM@ky.gov KCHIP: https://kidshealth.ky.gov/Pages/index.aspx | 877.524.4718 Medicaid: https://chfs.ky.gov
LOUISIANA – Medicaid
www.medicaid.la.gov or www.ldh.la.gov/lahipp 888.342.6207 (Medicaid hotline) or 855.618.5488 (LaHIPP)
MAINE – Medicaid
Enrollment: http://www.maine.gov/dhhs/ofi/public-assistance/index.html 800.442.6003 | TTY: Maine relay 711 Private Health Insurance Premium: https://www.maine.gov/dhhs/ofi/applications-forms 800.977.6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
https://www.mass.gov/info-details/masshealth-premium-assistance-pa 800.862.4840

MINNESOTA – Medicaid
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp 800.657.3739
MISSOURI – Medicaid
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm 573.751.2005
MONTANA – Medicaid
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP 800.694.3084
NEBRASKA – Medicaid
http://www.ACCESSNebraska.ne.gov Phone: 855.632.7633 | Lincoln: 402.473.7000 | Omaha: 402.595.1178
NEVADA – Medicaid
http://dhcfp.nv.gov 800.992.0900
NEW HAMPSHIRE – Medicaid
https://www.dhhs.nh.gov/oii/hipp.htm 603.271.5218 | Toll free number for the HIPP program: 800.852.3345, ext. 5218
NEW JERSEY – Medicaid and CHIP
Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid 609.631.2392 CHIP: http://www.njfamilycare.org/index.html 800.701.0710
NEW YORK – Medicaid
https://www.health.ny.gov/health_care/medicaid/ 800.541.2831
NORTH CAROLINA – Medicaid
https://medicaid.ncdhhs.gov/ 919.855.4100
NORTH DAKOTA – Medicaid
http://www.nd.gov/dhs/services/medicalserv/medicaid 844.854.4825
OKLAHOMA – Medicaid and CHIP
http://www.insureoklahoma.org 888.365.3742
OREGON – Medicaid
http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html 800.699.9075

PENNSYLVANIA – Medicaid
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx 800.692.7462
RHODE ISLAND – Medicaid and CHIP
http://www.eohhs.ri.gov 855.697.4347 or 401.462.0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
http://www.scdhhs.gov 888.549.0820
SOUTH DAKOTA – Medicaid
http://dss.sd.gov 888.828.0059
TEXAS – Medicaid
http://gethipptexas.com 800.440.0493
UTAH – Medicaid and CHIP
Medicaid: https://medicaid.utah.gov CHIP: http://health.utah.gov/chip 877.543.7669
VERMONT – Medicaid
http://www.greenmountaincare.org 800.250.8427
VIRGINIA – Medicaid and CHIP
https://www.coverva.org/hipp/ Medicaid: 800.432.5924 CHIP: 855.242.8282
WASHINGTON – Medicaid
https://www.hca.wa.gov/ 800.562.3022
WEST VIRGINIA – Medicaid
http://mywvhipp.com/ 855.MyWVHIPP (855.699.8447)
WISCONSIN – Medicaid and CHIP
https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm 800.362.3002
WYOMING – Medicaid
https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ 800.251.1269

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20220 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact Human Resources.

Women's Health and Cancer Rights Act Annual Notice

On October 21, 1998 the federal government passed the Women's Health and Cancer Rights Act of 1998. As part of our plan's compliance with this Act, we are required to provide you with this annual notice outlining the coverage that this law requires our plan to provide.

Our group health plan has always provided coverage for medically-necessary mastectomies. This coverage includes procedures to reconstruct the breast, on which the mastectomy was performed, as well as the cost of necessary prostheses (implants, special bras, etc.) and treatment of any physical complications resulting from any stage of the mastectomy. However, as a result of this federal law, the plan now provides coverage for surgery and reconstruction of the other breast to achieve a symmetrical appearance and any complications that could result from that surgery.

The following benefits must be provided if benefits are provided for a mastectomy:

1. Coverage for reconstruction of the breast on which the mastectomy is performed.
2. Coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance with the breast on which the mastectomy is performed.
3. Coverage for prostheses and physical complications resulting from any stage of the mastectomy, including lymph edemas.

These benefits are subject to the same deductible, copayments and coinsurance that apply to mastectomy benefits under the Eastern Carver County Schools plan you are enrolled in.

Notification of Possible Federal Public Service Loan Forgiveness Eligibility

Minnesota Statutes Section 136A.1792, covers promotion of federal public service loan forgiveness programs. Please be aware that you may be eligible for federal public service loan forgiveness of the remaining balance due on certain federal student loans after you have made 120 qualifying payments on those loans while employed full-time by certain public service employers.

For detailed information including how to monitor your progress toward qualifying for PSLF, read the PSLF Questions and Answers documents at www.StudentAid.gov/publicservice or contact your federal loan servicer

Statement of Nondiscrimination for Health Plan Members

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)

Español *(Spanish)*	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-883-2177. (TTY: 711)
Hmoob *(Hmong)*	LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-883-2177. (TTY: 711)
Tiếng Việt *(Vietnamese)*	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-883-2177. (TTY: 711)
繁體中文 *(Chinese)*	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-883-2177. (TTY: 711)
Русский *(Russian)*	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)
Af Soomaali *(Somali)*	OGAYSIIS: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)

Additional languages listed on page 2

ພາສາລາວ *(Laotian)*	ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-883-2177. (TTY: 711)
Deutsch *(German)*	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-883-2177. (TTY: 711)
العربية *(Arabic)*	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-883-2177(رقم هاتف الصم والبكم: 711
Français *(French)*	ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)
한국어 *(Korean)*	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-883-2177. (TTY: 711)
Tagalog *(Tagalog)*	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)
Oroomiffa *(Cushite [Oromo])*	XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-883-2177. (TTY: 711)
አማርኛ *(Amharic)*	ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-883-2177. (መስማት ለተሳናቸው: 711)
unD *(Karen)*	ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ၣ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လိၤ. ကိး 1-800-883-2177. (TTY: 711)
ខ្មែរ *(Mon-Khmer, Cambodian)*	ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-883-2177. (TTY: 711)
Deitsch *(Pennsylvanian Dutch)*	Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-883-2177. (TTY: 711)
Polski *(Polish)*	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-883-2177. (TTY: 711)
हिंदी *(Hindi)*	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-883-2177. (TTY: 711)
Shqip *(Albanian)*	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-883-2177. (TTY: 711)
Srpsko-hrvatski *(Serbo-Croatian)*	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-883-2177. (TTY: 711)
ગુજરાતી *(Gujarati)*	સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-883-2177. (TTY: 711)
اردو *(Urdu)*	خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-800-883-2177 (TTY: 711).
Italiano *(Italian)*	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)
ภาษาไทย *(Thai)*	เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-883-2177. (TTY: 711)
ελληνικά *(Greek)*	ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-800-883-2177. (TTY: 711)
Diné Bizaad *(Navajo)*	Díí baa akó nínízin: Díí saad bee yániłti'go **Diné Bizaad**, saad bee áká'ánída'áwo'dę́ę́', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-883-2177. (TTY: 711)

This benefit summary prepared by

Gallagher

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