Helping you make informed choices about your employee benefits.

NATIVE AMERICAN COMMUNITY CLINIC
HONORING HEALTH AND TRADITION

2023

Benefit Guide

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If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 26-28 for more details.

Benefits Overview

Native American Community Clinic (NACC) is proud to offer a comprehensive benefits package briefly summarized in this booklet.

You share the costs of some benefits and NACC provides other benefits at no cost to you. In addition, there are voluntary benefits that you can purchase at competitive rates through NACC.

Benefits Offered

- Medical
- Health Savings Account (HSA)
- Flexible Spending Account (FSA)
- Dental
- Base Life and AD&D—Employer–paid!
- Voluntary Life and AD&D
- Long-Term Disability (LTD) - Employer-paid!
- Voluntary Short-Term Disability (STD)
- Voluntary Critical Illness
- Voluntary Accident
- Voluntary Hospital Indemnity

Eligibility & Enrollment

Who is Eligible?

Employees working 30 hours or more are eligible to enroll in the benefits listed within this booklet.

When Can I Enroll in Benefits?

As a new hire, you are eligible for benefits on the 1st of the month following 30 days of employment.

If you do not enroll when first eligible, or within 31 days of a Qualified Life Event (QLE), you will have to wait until the next Annual Enrollment period.

Qualified Life Event (QLE) **-** If you experience a "Life Event" such as marriage, divorce, birth or adoption, or a change in your or your spouse's employment status that affects benefits eligibility anytime during the year, you can make changes to your benefit elections. You will be required to show official documentation as proof of the QLE such as a marriage license, birth certificate or court papers.

What Information do you Need to Enroll?

When enrolling yourself, you will need to have your address and social security number readily available. When enrolling your spouse and/or child(ren), you will need to have their name, address, date of birth, and social security number readily available for each dependent.

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	Policy Number	Phone	Website/Email
Medical	HealthPartners	See Benefit Chart Page 4	952.883.6000	www.healthpartners.com
Health Savings Account (HSA)	Further	98549	651.662.5065 or 800.859.2144	www.hellofurther.com
Flexible Spending Account (FSA)	AmeriFlex	AMFNACC	888.868.3539	www.myameriflex.com
Dental	Delta Dental of Minnesota	895901	800.553.9536	www.deltadentalmn.org
Life and AD&D	MetLife	5399772	800.438.6388	www.metlife.com
Voluntary Life and AD&D	MetLife	5399772	800.438.6388	www.metlife.com
Voluntary Short-Term Disability (STD)	MetLife	5399772	800.438.6388	www.metlife.com
Long-Term Disability (LTD)	MetLife	5399772	800.438.6388	www.metlife.com
Voluntary Critical Illness	MetLife	5399772	800.438.6388	www.metlife.com
Voluntary Accident	MetLife	5399772	800.438.6388	www.metlife.com
Voluntary Hospital Indemnity	MetLife	5399772	800.438.6388	www.metlife.com

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.

	BASE PLAN $3,000 Deductible Non-Embedded HSA PERFORM Policy ZD754	**BUY-UP PLAN $3,000 Deductible Non-Embedded HSA OPEN ACCESS Policy ZD753**	**BUY-UP PLAN $500 Deductible Copay PERFORM Policy ZD604**	**BUY-UP PLAN $500 Deductible Copay OPEN ACCESS Policy ZD603**
	In-Network	In-Network	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited	Unlimited	Unlimited	Unlimited
Annual Deductible	$3,000 single / $6,000 family	$3,000 single / $6,000 family	$500 single / $1,500 family	$500 single / $1,500 family
Annual Out-of-Pocket Maximum (includes deductible)	$3,000 single / $6,000 family	$3,000 single / $6,000 family	$3,750 single / $7,500 family	$3,750 single / $7,500 family
Coinsurance (Your % / Carrier %)	0% / 100%	0% / 100%	25% / 75%	25% / 75%
Doctor's Office				
Primary Care Visit	Deductible, then no charge	Deductible, then no charge	Primary Care Office Visit: $40 copay Convenience Care: $20 copay Virtuwell: No charge	Primary Care Office Visit: $40 copay Convenience Care: $20 copay Virtuwell: No charge
Specialist Office Visit	Deductible, then no charge	Deductible, then no charge	$40 copay	$40 copay
Preventive Care (routine exams, immunizations, Cancer Screening and mammograms)	No charge	No charge	No charge	No charge
Prescription Drugs				
Retail (31-day supply) *Generic Formulary (low/high)* *Brand Formulary* *Non-Formulary*	 Deductible, then no charge Deductible, then no charge Not covered	 Deductible, then no charge Deductible, then no charge Not covered	 $5 / $25 copay $60 copay $150 copay	 $5 / $25 copay $60 copay $150 copay
Mail-Order / 93-day Supply *Generic Formulary (low/high)* *Brand Formulary* *Non-Formulary*	 Deductible, then no charge Deductible, then no charge Not covered	 Deductible, then no charge Deductible, then no charge Not covered	 $15 / $75 copay $180 copay $450 copay	 $15 / $75 copay $180 copay $450 copay
Other Services				
Emergency Room	Deductible, then no charge	Deductible, then no charge	Deductible, then 25%	Deductible, then 25%
Urgent Care	Deductible, then no charge	Deductible, then no charge	$40 copay	$40 copay
Ambulance Service	Deductible, then no charge	Deductible, then no charge	Deductible, then 25%	Deductible, then 25%
Physical, Occupational and Speech Therapy Services *Inpatient* *Outpatient*	 Deductible, then no charge Deductible, then no charge	 Deductible, then no charge Deductible, then no charge	 Deductible, then 25% $40 copay	 Deductible, then 25% $40 copay
Durable Medical Equipment and Prosthetics	Deductible, then no charge	Deductible, then no charge	Deductible, then 25%	Deductible, then 25%
Skilled Nursing	Deductible, then no charge	Deductible, then no charge	Deductible, then 25%	Deductible, then 25%
Premiums—Bi-weekly (x26 pay periods)				
Employee	$0.00	$9.52	$55.07	$65.71
Employee + 1	$171.38	$194.89	$307.41	$333.69
Family	$265.82	$293.42	$425.53	$456.39

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/

Find a Physician or Facility

When you enroll in a medical plan through NACC, you have access to two networks of providers with HealthPartners; the Perform Network and Open Access Network. The Perform network is a comprehensive network of providers that includes the majority of your local clinics and hospitals, but excludes the Mayo from the network. The premiums for this network are cheaper than the Open Access network. If you would like care at the Mayo to be in-network, then you will need to choose the Open Access network. Make sure your current physician or provider is in your network. To search for a provider in your network, call HealthPartners Customer Service at 952.883.6000 or visit sign in to your member portal at www.healthpartners.com and search your provider listing.

HealthPartners' Value-Added Services

More than any other health plan, HealthPartners responds to your needs with tailor-made services and resources that support you in improving your health and making the most of your benefits. Best of all, these are all part of your benefit plan once you become a member. Call Customer Service for details on any of the resources below.

Wellbeats, Online Fitness Solution—*in 2023!*

Workout anytime, anywhere —just login to www.healthpartners.com on your browser or download the Wellbeats app for your Android or Apple iOS device. Wellbeats offers hundreds of classes, fitness assessments and challenges that can be easily accessed from home or on-the-go.

HealthPartners Health Discounts

Use your HealthPartners Member ID card to get discounts at many popular local and national retailers of health and well-being products and services. Discounts include: eyewear, fitness and wellness classes, healthy eating programs and delivery services, recreational equipment, spa services, swim lessons, pet insurance and more. For more details visit www.healthpartners.com/discounts.

BabyLine Phone Service

BabyLine helps expectant and new parents. Nurses help answer questions about your pregnancy, contractions, mood swings, morning sickness, healthy eating, safe medications and more. Available 24/7, 365 days a year by calling 800.845.9297.

Careline Nurse Phone Service

Immediate support is available for your health concerns 24 hours a day 7 days a week through HealthPartners Nurse Line. Access the nurse line at anytime by calling 800.551.0859.

Nurse Navigator Program

When you need help sorting out health and insurance issues, call our nurse navigators. They can help guide you through difficult decisions like choosing treatment options. Nurse Navigators will also research and coordinate healthcare based on your benefits and coverage. Available Monday through Friday, 7 a.m. to 7 p.m., CST. Contact member services for more information.

Pharmacy Navigators

Contact the pharmacy navigators for questions about your medications and pharmacy benefits under your plan. Available Monday through Friday, 8 a.m. to 6 p.m., CST. Contact member services for more information.

Behavioral Health Navigators

Talk to professionals who can help when you have questions about mental and chemical health network, benefits and services. Available Monday through Friday, 8 a.m. to 5 p.m., CST. Contact member services for more information.

Online Care Benefits—Virtuwell & Doctor on Demand

No doctor's office required! Care, treatment and prescriptions from home, work, or on-the-go. Talking to a doctor or nurse has never been easier. Get medical advice fast right from your computer or mobile device. It's like the doctor's office, without the appointment.

Virtuwell—Get care 24/7, 365 days a year at virtuwell.com. Nurse practitioners diagnose and treat more than 60 common conditions including bladder infections, sinus infections, pink eye, seasonal allergies and more. You'll get a diagnosis, treatment plan and prescription—all in about 30 minutes. You're only charged if they can treat you. Have questions about your treatment plan? Unlimited follow-up calls are free. If you enroll in the $500 Deductible Copay plan, Virtuwell is covered at 100%. If you enroll in the $3,000-100% Deductible Non-Embedded HSA Plan, you pay a $59 copay per visit until you meet your deductible. After you have met your deductible, Virtuwell is covered at 100%. You must live in, or be traveling to, one of the states that virtuwell serves. Visit virtuwell.com/faq to view the list of states.

Doctor on Demand—Schedule a visit with a board-certified physician at doctorondemand.com, or use the free Doctor On Demand mobile app. If you enroll in the $500 Deductible Copay Plan, you pay a $40 copay for a 15-minute visit. If you enroll in the $3,000 Deductible Non-Embedded HSA Plan, you pay a $59 copay for a 15-minute visit until you meet your deductible. After you have met your deductible, Doctor On Demand is covered at 100%. Visit doctorondemand.com to view cost for care services and service area.

Assist America Travel Benefit

Assist America provides all the support your need when you're more than 100 miles from home. They can help you with:

- Coordinating transport to care facilities or back home
- Filling lost prescriptions
- Finding good doctors
- Getting admitted to the hospital
- Pre-trip info, like immunization and visa requirements
- Tracking down lost luggage
- Translator referrals
- And more!

Visit healthpartners.com/getcareeverywhere or use the Assist America mobile app.

Dental

Administered by Delta Dental of Minnesota

Good oral care enhances your overall physical health, appearance, and mental well-being. Keep your teeth healthy and your smile bright with NACC's dental benefit plan through Delta Dental of Minnesota.

When you enroll in dental coverage, you have access to Delta Dental's unique dual-network, which allows you to choose from a broader selection of dentists within both of the following networks:

Delta Dental PPO℠ gives you the lowest out-of-pocket costs. Participating dentists in the network agree to accept lower fees for procedures, providing larger discounts that result in savings for Delta Dental members.

Delta Dental Premier® is the largest dental network in the country. In fact, more than 4 out of 5 dentists in the nation have agreed to accept Delta Dental's pre-negotiated fees for dental procedures.

As a Delta Dental subscriber, you may see any dentist. However, when you select a dentist within the Delta Dental PPO or Delta Dental Premier networks, you are guaranteed the fullest benefits from your program. If you seek dental care from a provider out-of-network, you will be responsible for paying any remaining balance above Delta Dental's contracted rate. To find a network provider near you, call Delta Dental's Customer Service at 800.553.9536 or visit www.deltadentalmn.org.

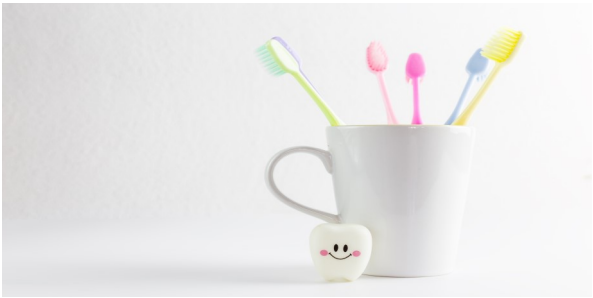
Services	Delta Dental PPO Network	Delta Dental Premier Network	Out-of-Network
Annual Deductible	$50 per person $150 per family		
Annual Benefit Maximum (per person per calendar year)	$1,000		
Diagnostic & Preventive Service Examinations Cleanings (2x/year) X-rays Periodontal maintenance	100%	80%	80%
Basic Services Space Maintainers Emergency Palliative Treatment—temporary pain relief Sealants—to prevent decay of permanent teeth Minor Restorative Services—fillings Anesthesia Services—medically necessary	80%	50%	50%
Major Restorative Services Crown Repair* Endodontic Services*—root canals Periodontic Services*—to treat gum disease Oral Surgery Services*—extractions and dental surgery Major Restorative Services*—crowns Other Basic Services*—miscellaneous services Prosthetic Services*—bridges and dentures Relines and Repairs*—to bridges and dentures TMD Treatment*	50%	50%	50%

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/ exclusions, please refer to the Dental Benefit Plan Summary.

**Benefit Waiting Period: It is very important when you first enroll in the dental plan to check if there are any Waiting Periods for certain services and procedures if you are planning future dental work. There is a 6-month waiting period for certain services. Endodontic Services, Periodontic Services, Extractions, and TMD Treatment will not be covered until after a person is enrolled in the dental plan for 6 consecutive months. Crown Repair, Major Restorative Services, Other Basic Services, Relines and Repairs, and Prosthodontic Services will not be covered until after a person is enrolled in the dental plan for 12 consecutive months.*

Premiums—Bi-weekly (x26 pay periods)

	Employee Contribution
Employee	$0.00
Employee + 1 / + Spouse	$7.88
Employee + Child(ren)	$11.76
Family	$18.68



Health Savings Account (HSA)

Administered by Further

You are eligible to open a Health Savings Account if you enroll in the $3,000 Deductible Non-Embedded HSA Plan offered by NACC.

What is a Health Savings Account (HSA)?

A Health Savings Account (HSA) is an account that can be funded with your tax-exempt dollars, by you, your employer, or both, to help pay for eligible medical expenses not covered by an insurance plan, including the deductible, coinsurance, and even in some cases, health insurance premiums.

IMPORTANT: If you have a FSA Health Reimbursement Account, your balance must be exhausted prior to establishing/contributing to a HSA. This means you should allow enough time for your last FSA reimbursements to be processed and the account to reflect a $0 balance.

Who funds your HSA Account?

You are encouraged to contribute to your HSA account through pre-tax payroll deduction. NACC will also contribute to your HSA in the following amounts:

- $1,000 for Employee-Only coverage
- $1,800 for Employee+1 or Family coverage

When and how often can I contribute to my Health Savings Account (HSA)?

You can contribute to your HSA account through a payroll deduction(s) or as a lump sum deposit. You can contribute as often as you like, provided the annual 2023 contributions do not exceed the following limits:

- $3,850 for Employee-Only coverage
- $7,750 for Employee+1 or Family coverage

Individuals that are age 55 or older by the end of the tax year are eligible to make an additional contribution up to $1,000.

How does the plan work?

In-Network Preventive Care

In-network preventive care such as annual check-ups, cancer screenings, well-child care and immunizations are covered at 100% and some preventive prescriptions.

Use your HSA to help pay these expenses

DEDUCTIBLE
$3,000 Individual
$6,000 Family

You pay 100% of medical and prescription drug costs until you meet your deductible. You may make contributions to your HSA pre-tax up to the IRS maximum. You can withdraw these funds tax-free and put them towards meeting your deductible or save them to help offset future expenses.

Out-of-Pocket Maximum
$3,000 Individual
$6,000 Family

Due to the structure of NACC's HSA plan, by virtue of reaching your deductible, you have satisfied your out-of-pocket max. The plan will now pay 100% for the remainder of the calendar year.

Frequently Asked Questions about HSAs

Who is eligible for an HSA?

Anyone who is:

- Enrolled in NACC's $3,000 Deductible Non-Embedded HSA Plan;
- Not covered under another medical plan that is not a qualified HDHP, including a traditional medical flexible spending account (FSA), that either you or your spouse is enrolled in;
- Not entitled to Medicare benefits; or
- Not eligible to be claimed on another person's tax return.

What is a qualified High Deductible Health Plan (HDHP)?

A qualified High Deductible Health Plan is a plan with a minimum annual deductible and a maximum out-of-pocket limit as listed below. These minimums and maximums are determined annually by the Internal Revenue Service (IRS) and are subject to change.

How do I manage my HSA?

The HSA account is your account; the HSA dollars are your dollars. Since you are the account holder or HSA beneficiary, you manage your HSA account. You may choose when to use your HSA dollars or when not to use your HSA dollars. HSA dollars pay for any eligible expense. Most commonly, the HSA account holder will pay their out-of-pocket expenses (i.e. deductible and coinsurance) associated with their high deductible health plan with their HSA dollars.

What expenses are eligible for reimbursement from my HSA?

HSA dollars may be used for qualified medical expenses incurred by the account holder and his or her spouse and dependents. Qualified medical expenses are expenses for medical care and are outlined within IRS Section 213(d). In summary, the IRS Section 213(d) states that "the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness."

In addition to qualified medical expenses, the following insurance premiums may be reimbursed from an HSA:

- COBRA premiums;
- Health insurance premiums while receiving unemployment benefits;
- Qualified long-term care premiums; and
- Any health insurance premiums paid, other than for a Medicare supplemental policy, by individuals ages 65 and over (assuming premiums are not collected through payroll on a pre-tax basis).

What if I have HSA dollars left in my account at year-end?

The money is yours to keep. It will continue to earn interest and will be available for you and your healthcare costs next year. Any dollars left in your HSA account at year-end will automatically roll over into next year's HSA account.

Can I use the money in my account to pay for my dependents' medical expenses?

You can use the money in the account to pay for medical expenses for yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by NACC's $3,000 Deductible Non-Embedded HSA Plan.

What happens to my HSA dollars if I leave my employer?

The funds are yours to keep. You may elect one of the following options:

- Leave your funds in the current HSA account;
- Transfer your funds to an HSA with your new employer (check to make sure there are no fees associated with the transfer); or
- Transfer your funds to another qualifying account within 60 days.

Flexible Spending Account (FSA)

Administered by Ameriflex

Easy and convenient, a Flexible Spending Account (FSA) allows you and your family to save money on medical and/or dependent care expenses. You have the opportunity to set aside funds each pay period on a pre-tax basis. Per paycheck contributions, which are determined by you and can only be changed one time per year during annual enrollment (or for a qualifying event), will be deposited into your FSA account.

You do not have to be enrolled in the company medical, dental or vision to enroll in a FSA. You manage your FSA funds; you may not use money from your Health Care FSA to pay for dependent care expenses, or vice versa. You must re-enroll every year during Annual Enrollment in order to participate in the FSA benefit plan.

Please Note: The IRS does not allow you to have both a full Health Care FSA Account and a HSA. However, you can open a Limited-Purpose FSA (LPFSA) in conjunction with a HSA by using your HSA funds to pay for medical expenses and your LPFSA funds to pay for your dental and vision expenses. See details below.

Health Care FSA Account

After you make your Health Care FSA election, you will automatically receive a Health Care Account Debit Card in the mail that you can use to pay for eligible health care expenses. You can also pay for your expenses out-of-pocket and then submit a claim form and receipts for reimbursement. It is important to always save your receipts for eligible health care expenses in order to be reimbursed. The Health Care FSA Account is subject to contribution maximums that differ from the Dependent Care FSA Account; see amounts listed below.

Limited Purpose FSA Account

If you are participating in the Health Savings Account (HSA) paired with the $3,000 Deductible Non-Embedded HSA Plan, you may not enroll in the Health Care FSA Account. You may enroll in a Limited Purpose FSA Account. You may use your Limited Purpose FSA Account to pay for dental, vision, and post-deductible expenses ONLY. Your Limited Purpose FSA Account is subject to the same contribution limitations as the Health Care FSA Account.

Dependent Care FSA Account

After you make your Dependent Care FSA election, you will need to pay for your expenses out-of-pocket and submit a claim form and receipts for reimbursement. The Dependent Care FSA Account is subject to contribution maximums that differ from the Health Care FSA Account; see amounts listed below.

How much can I contribute to my FSA Account?

The IRS limits how much you can contribute tax-free into your FSA Account. Depending on which FSA account type you choose, your contribution limits in 2023 are as follows:

Health Care FSA or Limited Purpose FSA—$3,050

Dependent Care FSA—$5,000 for married couples filing jointly or for single head of household; $2,500 for married couples filing separately

Up to $610 of any remaining balance left in your Healthcare FSA at the end of the plan year can be carried over into the next plan year. Any remaining balance over $610 will be forfeited and not carried over into the next year.

What is an eligible expense?

To find information on eligible expenses for your dependent care FSA, go to www.irs.gov and search for Publication 502 and 503 [Section 213(d)]

Life and Accidental Death & Dismemberment (AD&D) Insurance

Insured by MetLife

This benefit is 100% paid by NACC, and provides you with Life and Accidental Death & Dismemberment (AD&D) insurance of $20,000. The benefit will be reduced to 65% when you reach age 65 and 50% when you reach age 70.

Voluntary Life and Accidental Death & Dismemberment (AD&D) Insurance

Insured by MetLife

You may purchase Life and AD&D insurance for yourself, your spouse and dependent children on a payroll deduction basis. When you first become eligible, you can purchase up to the guarantee issued coverage without answering medical questions. If you apply for coverage that is above the Guaranteed Issue Amount, or if you are applying for coverage after your initial eligibility period, you must fill out a Medical Evidence of Insurability (EOI) form. This is a Term Life Policy and does not build cash value. The benefit will be reduced to 65% when you reach age 65 and to 50% when you reach age 70.

Employee Voluntary Life

You may purchase in increments of:	$10,000
Guarantee Issue Amount:	$150,000
Maximum amount you can purchase:	5x annual earnings to maximum of $500,000

Spouse Voluntary Life

If you choose to enroll yourself, you may also enroll your spouse in Voluntary Life coverage.

You may purchase in increments of:	$5,000
Guarantee Issue Amount:	$25,000
Maximum amount you can purchase:	Lesser of $100,000 or 50% of employee coverage

Child(ren) Voluntary Life

If you choose to enroll yourself, you may also enroll your child(ren) in Voluntary Life coverage.

Amount you may purchase:	Increments of $1,000, $2,000, $4,000, $5,000 or $10,000

The benefit available for children from 15 days to 6 months old is limited to $100. The full child Life amount of $10,000 that may be purchased is guaranteed without needing to provide Evidence of Insurability.

Employee Voluntary AD&D

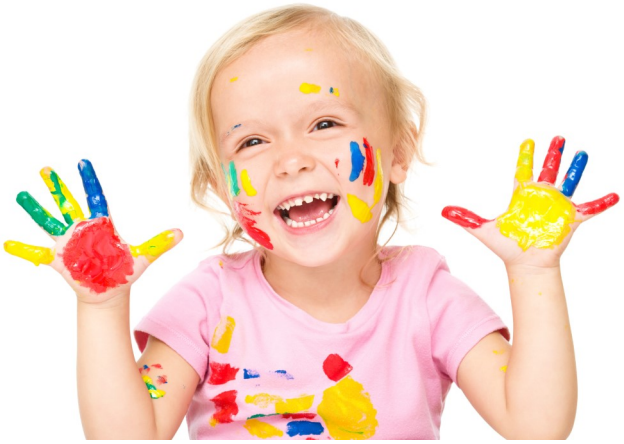
You may purchase Voluntary AD&D on yourself in an amount equal to your Voluntary Life election.

Spouse and Child(ren) Voluntary AD&D

If you choose to enroll yourself, you may also enroll your spouse and dependent child(ren) in Voluntary AD&D for an amount equal to their Voluntary Life elections.

Guaranteed Issue -
If you are in your initial eligibility period for benefits, you may elect up to the full Guarantee Issue amount without being required to submit Evidence of Insurability. For amounts over Guarantee Issue Amount of $150,000 for you or $25,000 for your spouse, you must complete an Evidence of Insurability form and be approved for the coverage. If the additional amount over Guarantee Issue for you or your spouse is declined, you will still receive the Guarantee Issue Amount. All Child Life amounts of coverage are Guaranteed Issue without EOI.

If you previously waived coverage and are enrolling during Open Enrollment, any amount of coverage you apply for requires you to complete an Evidence of Insurability form and be approved, even if you are applying for coverage under the Guarantee Issue amounts noted above.



Premiums

Supplemental Life and AD&D Rates per $1,000		
Age*	**Employee Life**	**Spouse Life**
< 30	$0.026	$0.026
30-34	$0.055	$0.055
35-39	$0.087	$0.087
40-44	$0.132	$0.132
45-49	$0.200	$0.200
50-54	$0.291	$0.291
55-59	$0.402	$0.402
60-64	$0.495	$0.495
65-69	$0.717	$0.717
70+	$1.353	$1.353
Employee / Spouse AD&D	$0.015	$0.015
Child Life / AD&D	$0.240* / $0.054	

**The premium paid for child coverage is based on the cost of coverage for one child, regardless of how many children you have. Children are eligible up to age 19 or 26 if a full-time student.*

What will it cost you per paycheck?

Example Per Paycheck Rate Calculated

A **38-year-old employee elects $50,000 of Voluntary Supplemental Life without Voluntary AD&D** coverage.

Per Paycheck Rate Calculation Tool

	Life Amount Selected	Multiplied by Rate (from table)	Divided by 1,000 (equals your monthly cost)	Multiplied by 12 months; divided by 26 pay periods (equals your cost per paycheck)
Employee Supplemental Life	$50,000	$0.087 =_____	/ 1,000 = $4.35	X 12 / 26 =_____

	Life Amount Selected	Multiplied by Rate (from table)	Divided by 1,000 (equals your monthly cost)	Multiplied by 12 months; divided by 26 pay periods (equals your cost per paycheck)
Employee Supplemental Life	$_____	x _____	/ 1,000 = $_____	X 12 / 26 =_____
Employee Supplemental AD&D	$_____	x $0.015	/ 1,000 = $_____	X 12 / 26 =_____
Spouse Supplemental Life	$_____	x _____	/ 1,000 = $_____	X 12 / 26 =_____
Spouse Supplemental AD&D	$_____	x $0.015	/ 1,000 = $_____	X 12 / 26 =_____
Child Supplemental Life	$_____	x $0.240	/ 1,000 = $_____	X 12 / 26 =_____
Child Supplemental AD&D	$_____	x $0.054	/ 1,000 = $_____	X 12 / 26 =_____

Voluntary Short-Term Disability (STD)

Administered by MetLife

If you become disabled, you may be unable to work and, therefore, your income may be reduced. Unfortunately, your expenses and bills always continue. You have the option to purchase Voluntary Short-Term Disability insurance for qualified accident or illness/ pregnancy.

Benefit Options	
Waiting Period	14 days for injury 14 days for illness
Percentage of Income Replacement	60% to weekly maximum of $1,000
Plan Features	
Maximum Benefit Period	11 weeks; Maternity: 6 weeks (8 weeks for C-section)

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/ exclusions, please refer to the STD Plan Summary.

Common Reasons to Purchase this Protection	
• *Injuries*	• *Normal Pregnancy*
• *Back Disorders*	• *Digestive Disorders*
• *Joint Disorders*	

Reasons to Buy This Coverage at Work - TODAY!	
1)	*Competitive group rates you won't find outside your workplace*
2)	*Premium is conveniently deducted from your paycheck*

Premiums

Voluntary Short-Term Disability Rates per $10	
Age*	**Rate**
< 30	$0.440
30-34	$0.458
35-39	$0.415
40-44	$0.449
45-49	$0.544
50-54	$0.682
55-59	$0.829
60-64	$0.985
65+	$1.183

What will it cost you per paycheck?

1) Calculate your weekly disability benefit.

Enter your annual earnings	Divided by 52 equals your weekly earnings	Multiplied by % of income replacement	Max weekly benefit available (cannot exceed $1,000)
$ _____	/ 52 = $ _____	x 60%	= $ _____

2) Calculate your cost per paycheck (x26 pay periods).

Enter the monthly benefit amount you would want if disabled. Enter your rate from the rate chart above.

Maximum weekly benefit	Divided by 10	Multiplied by your rate	Your monthly cost x 12	Your annual cost	Divided by number of pay periods per year (26)
$ _____	/ 10 = $ _____	x _____	= $ _____ x 12	= $ _____	/ 26 = $_____

Long-Term Disability (LTD)

Administered by MetLife

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. Over a long period of time, this can eat through the financial safety nets you've worked hard to build. This long-term benefits provides protection for your most valuable asset - your ability to earn an income. Long-term disability benefits are considered taxable wages.

Benefit Summary	
Elimination Period	90 days of disability
Percentage of Income Replacement	60% to a maximum monthly benefit of $2,000
Maximum Benefit Period	Reducing Benefit Duration with Social Security Normal Retirement Age
Pre-Existing Condition Limitation	**3/12** A pre-existing condition is a condition for which you received medical treatment, consultation, care or services including diagnostic measures, or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage; and the disability begins in the first 12 months after your effective date of coverage.

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/ exclusions, please refer to the LTD Plan Summary.

Voluntary Critical Illness with Cancer

Administered by MetLife

Out-of-pocket costs associated with an unexpected health issue can be as high as $14,444 for a critical illness, according to a recent survey. Recent studies have shown 42% of all personal bankruptcies are a result of medical expenses. The study also reveals that 78% of those who filed had medical insurance.

Plan Details	
Benefit	**Employee:** $5,000 or $10,000; **Spouse:** 50% of the employee benefit amount **Child:** 50% of the employee benefit amount
Guarantee Issue	Coverage is guaranteed provided (1) the employee is actively at work and (2) dependents are not subject to medial restrictions as set forth on the enrollment form and in the certificate. Some states require the insured to have medical coverage.
Covered Conditions	Benefits are paid out for a number of critical diagnoses, including Alzheimer's disease, Coronary Artery Bypass graft, Cancer, Heart Attack, Kidney Failure, Major Organ Transplant, Stroke, etc. There are specific childhood conditions for enrolled dependents including, Cerebral Palsy, Cleft Lip/Palate, Cystic Fibrosis, Down Syndrome, Sickle Cell Anemia, and Spina Bifida. The covered illnesses are covered on a specific schedule of benefits. The list of illnesses listed above is illustrative and does not include all covered illnesses under the plan. For a full plan summary, please review a carrier plan summary or consult your Critical Illness policy.
Pre-Existing Conditions	12 months prior / excluded for 12 months after
Additional Features	**Portability:** You can keep your coverage if your employment status changes.

Monthly Premium per $1,000 of Coverage								
Age	Non-Tobacco User				Tobacco User			
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$0.64	$1.07	$0.94	$1.37	$0.78	$1.27	$1.08	$1.57
25-29	$0.73	$1.20	$1.03	$1.50	$0.94	$1.51	$1.24	$1.81
30-34	$0.86	$1.39	$1.16	$1.69	$1.18	$1.87	$1.48	$2.17
35-39	$1.04	$1.67	$1.34	$1.97	$1.52	$2.39	$1.82	$2.69
40-44	$1.34	$2.13	$1.64	$2.43	$2.08	$3.24	$2.38	$3.54
45-49	$1.64	$2.61	$1.94	$2.91	$2.63	$4.10	$2.93	$4.40
50-54	$2.00	$3.18	$2.30	$3.48	$3.27	$5.12	$3.57	$5.42
55-59	$2.40	$3.81	$2.70	$4.11	$3.98	$6.24	$4.28	$6.54
60-64	$2.78	$4.41	$3.09	$4.71	$4.62	$7.25	$4.92	$7.55
65-69	$2.94	$4.64	$3.24	$4.94	$4.84	$7.59	$5.14	$7.89
70-74	$2.90	$4.55	$3.20	$4.85	$4.67	$7.30	$4.98	$7.60
75+	$3.68	$5.71	$3.98	$6.02	$5.88	$9.11	$6.18	$9.41

What will it cost you per paycheck?

Example Per Paycheck Rate Calculated

A **38-year-old employee** elects **$10,000** of **Voluntary Critical Illness** coverage **himself** without wellness coverage. He is **not a tobacco user**.

	Critical Illness Amount Selected	Multiplied by Rate (from table)	Divided by 1,000 (equals your monthly cost)	Times 12 months / Divided by 26 pay periods per year (26)
Employee Critical Illness	$10,000	X $1.04	/ 1,000 = $10.40	X 12/ 26 = $4.80

Per Paycheck Rate Calculation Tool

	Critical Illness Amount Selected	Multiplied by Rate (from table)	Divided by 1,000 (equals your monthly cost)	Times 12 months / Divided by 26 pay periods per year (26)
Employee Critical illness ($5,000 or $10,000)	$ _____	x _____	/ 1,000= $ _____	X 12 / 26 = $_____

Voluntary Accident Insurance

Administered by MetLife

Accidents can lead to trips to the emergency room and the doctor's office, which could amount to bills and expenses not covered by your medical and disability insurance. Recent studies have shown 42% of all personal bankruptcies are a result of medical expenses. The study also reveals that 78% of those who filed had medical insurance.

Accidents can happen any time, to anyone and when you least expect them – and they can be costly. Even quality medical plans can leave you with extra expenses to pay. Having the financial support you may need when the time comes means less worry for you and your family.

	Plan Benefits
Benefit	24-hour Coverage (on-and off-job)
Schedule of Benefits	A summary of benefits is included on the next page; a full schedule of benefits can be found in the Certificate of Coverage.
Additional Features	Portability: You can keep your coverage if your employment status changes.

This is a summary of benefits only and does not guarantee coverage. For a complete list of covered services and limitations/exclusions, please refer to the Plan Summary.

How it works

Rob bought a new bike so he could lose a few pounds — but he lost his balance instead. He was diagnosed with a dislocated ankle and a broken toe. Rob had one lucky break — his accident insurance paid him $1,950!

Covered Event	Benefit Amount
Ambulance (ground)	$400
Emergency Care	$200
Fractured Toe	$200
Follow-up Visits (x 2)	$150
Dislocated Ankle	$1,000
Total Benefit	**Benefit $1,950**

Premiums—Monthly

	Monthly Premium
Employee	$8.07
Employee + Spouse	$15.73
Employee + Child(ren)	$18.84
Family	$22.22

**To calculate your cost per pay period, multiply your monthly cost by 12 months to get your annual cost, and divide by 26 pay periods to get your cost per paycheck.*

Per Paycheck Rate Calculation Tool

	Monthly Cost multiplied by 12 months equals your annual cost	Divided by 26 pay periods equals your cost per paycheck
Choose your coverage options	$ _____ x 12	/ 26 = $_____

A schedule of covered injuries is included on the next page.

Be Sure to Review this Summary of Benefits -It shows the many ways this coverage can pay a benefit if you are injured

Summary of Benefits	
Accidental death (Employee/spouse/Child)	
Basic Accidental Death Benefit	$50,000 / $20,000 / $10,000
*AD common Carrier Benefit***	$150,000 / $60,000 / $30,000
Fracture Benefit (Closed / Open Reduction)	
Skull (except face or nose) , depressed	$5,000 / $10,000
Skull (except face or nose), non-depressed	$2,500 / $5,000
Upper Arm (humerus)	$2,000 / $4,000
Rib	$1,000 / $2,000
Finger , Toe	$200 / $400
Pelvis	$2,000 / $4,000
Hip, Thigh (femur)	$5,000 / $10,000
Kneecap (patella)	$750 / $1,500
Ankle	$750 / $1,500
Foot (except toes)	$750 / $1,500
Full Dislocation (Closed / Open Reduction)	
Collarbone (sternoclavicular)	$1,500 / $3,000
Collarbone (acromioclavicular and separation)	$1,000 / $2,000
Shoulder	$1,000 / $2,000
Elbow	$1,000 / $2,000
Wrist	$1,000 / $2,000
Hip	$5,000 / $10,000
Ankle	$1,000 / $2,000
Finger or Toe joint	$200 / $400
Burn– 2nd degree	
35% or more of surface skin burnt	$1,500
Burn– 3rd degree	
10%-25% surface skin burnt	$2,500
25%-35% surface skin burnt	$7,500
35+ square inches	$15,000
Medical Treatment and Services Benefits	
Air Ambulance	$1,500
Ground Ambulance	$400
Medical Testing / Imaging	$200
Physician Follow-Up Visit Benefit (2 per accident)	$75
Transportation	$400
Emergency Care Benefit	
Emergency Room	$200
Physician's Office	$100
Urgent Care	$75

** For a full listing, review your Plan Document.*

*** Common Carrier refers to airplanes, trains, buses, trolleys, subways and boats. Certain conditions apply. See your Disclosure Statement or Outline of Coverage/Disclosure Document for specific details.*

Voluntary Hospital Indemnity Insurance

Insured by MetLife

Hospital Indemnity insurance pays our a lump sum benefit directly to you when you have a covered hospital stay. This plan is ideal if you can anticipate having a hospital stay this plan year (i.e. if you are pregnant, etc.). This coverage helps to offset the high cost of copays, deductibles, and other expenses your medical insurance doesn't cover.

Plan Details	Low Plan	High Plan
Hospital Admission	$500 per calendar year (up to 4 times per year)	$1,500 per calendar year (up to 4 times per year)
Daily Hospital Confinement	$100 per day, to a maximum of 65 days per calendar year	$300 per day, to a maximum of 65 days per calendar year
ICU Admission	Additional $500 per admission	Additional $1,500 per admission
Daily ICU Confinement	Additional $100 per day, to a maximum of 65 days per calendar year	Additional $300 per day, to a maximum of 65 days per calendar year
Portability	Included; this an individually owned policy; you can keep your coverage if your employment status changes.	
Coverage Options	You can purchase coverage for yourself, your spouse, and dependent child(ren). You must purchase coverage for yourself in order to purchase coverage for your spouse or child(ren).	
Evidence of Insurability (Health Questions)	At initial enrollment, health questions are not required for the employee or spouse when first eligible.	

Family coverage options assume Employee and Spouse are in the same Age Band. If Employee and Spouse are in different Age Bands, the final Monthly Premium amounts will be different. Dependent Children issue ages are newborn up to their 26th birthday or to the maximum coverage age defined in the policy.

Premiums—Monthly

Low Plan	
Employee	$9.43
Employee + Spouse	$15.83
Employee + Children	$14.36
Family	$20.76

High Plan	
Employee	$25.92
Employee + Spouse	$43.53
Employee + Children	$39.49
Family	$57.09

Per Paycheck Rate Calculation Tool

**To calculate your cost per pay period, multiply your monthly cost by 12 months to get your annual cost, and divide by 26 pay periods to get your cost per paycheck.*

	Monthly Cost multiplied by 12 months	Divided by 26 pay periods equals
Choose your coverage options	$ _____ x 12	/ 26 = $_____

Legal Notices

1. Women's Health & Cancer Rights Act
2. Newborn's and Mother's Health Protection Act
3. Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
4. HIPAA Notice of Privacy Practices
5. HIPAA Special Enrollment Rights
6. Notice of Creditable Coverage
7. COBRA General Notice
8. Summary of Benefits and Coverage (SBC)

WOMEN'S HEALTH & CANCER RIGHTS ACT

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("WHCRA"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: BASE PLAN $3,000 Deductible Non-Embedded HSA Plan (Individual: 0% coinsurance and $3,000 deductible; Family: 0% coinsurance and $6,000 deductible)

Plan 2: BUY-UP PLAN $500 Deductible Copay Plan (Individual: 25% coinsurance and $500 deductible; Family: 25% coinsurance and $1,500 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 612.843.5995 or jsingh@nacc-healthcare.org.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 **1-877-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 **1-866-444-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 July 31, 2022. Contact your State for more information on eligibility –

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442

ARKANSAS – Medicaid	FLORIDA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900

MAINE – Medicaid	NEW HAMPSHIRE – Medicaid
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, 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 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

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

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights
Native American Community Clinic is committed to the privacy of your health information. The administrators of the Native American Community Clinic Health Plan (the "Plan") use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan's policies protecting your privacy rights and your rights under the law are described in the Plan's Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Jenny Singh – Finance at 612.843.5995 or jsingh@nacc-healthcare.org.

HIPAA SPECIAL ENROLLMENT RIGHTS

Native American Community Clinic Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Native American Community Clinic Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its "special enrollment provision" if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, 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 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or a state children's health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Jenny Singh – Finance at 612.843.5995 or jsingh@nacc-healthcare.org.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from Native American Community Clinic

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 Native American Community Clinic 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. **Native American Community Clinic has determined that the prescription drug coverage offered by the medical 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 Native American Community Clinic coverage will not be affected. The $500 Deductible Copay Plan offers the following prescription drug coverage for a 1-month supply: 100% coverage after a $5 copay for low-cost generic drugs, $25 copay for high-cost generic drugs, a $60 copay for preferred Brand drugs, and a $150 copay for non-preferred drugs. The $3,000 Deductible Non-Embedded HSA Plan offers the following drug coverage for a 1-month supply: 100% coverage after the deductible has been met. Members may keep this coverage if they elect part D and this plan will coordinate with Part D coverage. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Native American Community Clinic coverage, be aware that you and your dependents may 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 Native American Community Clinic 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 October 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 Native American Community Clinic 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:	**January 01, 2023**
Name of Entity/Sender:	**Native American Community Clinic**
Contact—Position/Office:	**Jenny Singh – Finance**
Office Address:	**1213 E. Franklin Avenue,** **Minneapolis, Minnesota 55404** **United States**
Phone Number:	**612.843.5995**

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights
(For use by single-employer group health plans)

**** Continuation Coverage Rights Under COBRA****

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: Jenny Singh.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov/**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.healthcare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Native American Community Clinic
Jenny Singh – Finance
1213 E. Franklin Avenue,
Minneapolis, Minnesota 55404
United States
612.843.5995

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document 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 those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.

Gallagher

Insurance | Risk Management | Consulting

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: $500 Individual, $1,500 Family Out-of-network: $7,500 Individual, $22,500 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. Coinsurance marked with * under What You Will Pay and copays and benefits with no charge 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/pharmacy: $3,750 Individual, $7,500 Family Out-of-network medical/pharmacy: $15,000 Individual, $30,000 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?	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 www.healthpartners.com/Perform 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 in-network 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	Primary Office Visit: $40 copay Convenience Care: $20 copay virtuwell: No charge	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	$40 copay	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% 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 Low Cost: $5 copay at retail, $15 copay at mail Formulary High Cost: $25 copay at retail, $75 copay at mail Non-formulary: $150 copay at retail, $450 copay at mail	Formulary: 50% coinsurance at retail, mail not covered Non-formulary: 50% coinsurance at retail, mail not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month.
	Formulary brand drugs	$60 copay at retail, $180 copay at mail	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	$150 copay at retail, $450 copay at mail	50% coinsurance at retail, mail not covered	
	Specialty drugs	25% coinsurance*	50% coinsurance at retail, mail not covered	$500 maximum copay per prescription.
If you have outpatient	Facility fee (e.g., ambulatory	25% coinsurance	50% 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)	
surgery	surgery center)			
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$40 copay	$40 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$40 copay	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$40 copay	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	$40 copay	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	$40 copay	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	25% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	25% coinsurance*	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	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.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, limit of 15 visits	• Hearing aids	• Routine eye care (Adult)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	

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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. 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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

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	$500
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$1,200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,790**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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: $500 Individual, $1,500 Family Out-of-network: $7,500 Individual, $22,500 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. Coinsurance marked with * under What You Will Pay and copays and benefits with no charge 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/pharmacy: $3,750 Individual, $7,500 Family Out-of-network medical/pharmacy: $15,000 Individual, $30,000 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?	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 www.healthpartners.com/OpenAccess 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 in-network 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	Primary Office Visit: $40 copay Convenience Care: $20 copay virtuwell: No charge	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	$40 copay	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	25% coinsurance	50% 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 Low Cost: $5 copay at retail, $15 copay at mail Formulary High Cost: $25 copay at retail, $75 copay at mail Non-formulary: $150 copay at retail, $450 copay at mail	Formulary: 50% coinsurance at retail, mail not covered Non-formulary: 50% coinsurance at retail, mail not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month.
	Formulary brand drugs	$60 copay at retail, $180 copay at mail	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	$150 copay at retail, $450 copay at mail	50% coinsurance at retail, mail not covered	
	Specialty drugs	25% coinsurance*	50% coinsurance at retail, mail not covered	$500 maximum copay per prescription.
If you have outpatient	Facility fee (e.g., ambulatory	25% coinsurance	50% 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)	
surgery	surgery center)			
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	$40 copay	$40 copay	None
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	50% coinsurance	None
	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	$40 copay	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	25% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	25% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	$40 copay	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	$40 copay	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	$40 copay	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	25% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	25% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	25% coinsurance*	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	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.)		
• Bariatric surgery	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Private-duty nursing	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture, limit of 15 visits	• Hearing aids	• Routine eye care (Adult)
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	

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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. 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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

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	$500
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,870**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$1,200
Coinsurance	$70
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,790**

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

The plan's overall deductible	$500
Specialist copay	$40
Hospital (facility) coinsurance	25%
Other coinsurance	25%

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	$500
Copayments	$200
Coinsurance	$400
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,100**

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: $3,000 Individual, $6,000 Family Out-of-network: $13,000 Individual, $26,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and benefits with no charge 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/pharmacy: $3,000 Individual, $6,000 Family Out-of-network medical/pharmacy: $20,000 Individual, $40,000 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, the overall family out-of-pocket limit must be 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 www.healthpartners.com/Perform 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 in-network 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	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% 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: 50% coinsurance at retail, mail not covered Non-formulary: Not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month. Preventive Drugs: Generic: No charge retail or No charge mail/prescription; Brand: $25 retail or $75 mail copay*/prescription
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	0% coinsurance	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% 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
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-

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)	
				network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	0% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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, limit of 15 visits • Chiropractic care	• Hearing aids • 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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. 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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

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	**$3,000**
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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$3,000**
Specialist 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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

The plan's overall deductible	**$3,000**
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**

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: $3,000 Individual, $6,000 Family Out-of-network: $13,000 Individual, $26,000 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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and benefits with no charge 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/pharmacy: $3,000 Individual, $6,000 Family Out-of-network medical/pharmacy: $20,000 Individual, $40,000 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, the overall family out-of-pocket limit must be 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 www.healthpartners.com/OpenAccess 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 in-network 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	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	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	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% 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: 50% coinsurance at retail, mail not covered Non-formulary: Not covered	Days Supply: 31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a $25 benefit cap per prescription per month. Preventive Drugs: Generic: No charge retail or No charge mail/prescription; Brand: $25 retail or $75 mail copay*/prescription
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	0% coinsurance	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% 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
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-

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)	
				network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	50% coinsurance	120 days per calendar year
	Durable medical equipment	0% coinsurance	50% coinsurance	Limited to one wig per year for Alopecia Areata
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Infertility treatment
- 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, limit of 15 visits • Chiropractic care	• Hearing aids • 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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. If your plan is not subject to ERISA, contact the US Dept. of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. If your plan is subject to ERISA; contact the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform. 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. For insured plans, call the MN Dept. of Commerce at 651-539-1600 / 1-800-657-3602. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

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	**$3,000**
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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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

The plan's overall deductible	**$3,000**
Specialist 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	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,020**

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

The plan's overall deductible	**$3,000**
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**

This benefit summary prepared by:

Gallagher

Insurance | Risk Management | Consulting

For:

NATIVE AMERICAN COMMUNITY CLINIC

HONORING HEALTH AND TRADITION