2025

ANOKA
REAL. CLASSIC.

Understanding Your Benefits

Table of Contents

Employee Communication Disclaimer

This Employee Benefit Manual is a summary of some of the main features of your benefit plans. The plans are administered according to legal documents and insurance contracts. Although we have tried to summarize the provisions of these legal documents clearly and accurately, if any information presented here conflicts with the legal documents, the legal documents will govern. For more detailed information on the plans and your legal rights under the plans, be sure to read the summary plan descriptions or request a copy of the plan documents.

If you 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 pages 30 - 31 for more details.

Contacts

Medical Insurance
Health Partners Member Service: 952-883-5000
or toll free at 800-883-2177
Website: www.healthpartners.com

HSA Administrator
Optum Bank Member Service: 855-687-2021
Website: www.optumbank.com

Dental Insurance
Delta Dental Member Service: 1-800-448-3815
Website: www.deltadentalmn.org

Disability Insurance
New York Life Member Service: 800-225-5695
Website: www.newyorklife.com

Life & Voluntary Life Insurance
New York Life Member Service: 800-225-5695
Website: www.newyorklife.com

Flexible Spending Account
Benefit Extras Member Service: 952-435-6858
Website: www.benefitextras.com

Enrollment

To enroll in your **Medical, Dental, Disability, Life, and Flex** plans, please complete the carrier's enrollment form.

For your **Life Insurance** plan, you will need to complete a beneficiary form designating a benefit recipient.

Overview

your benefits ...

When you think about your total compensation package, don't forget about your benefits. Along with your pay, City of Anoka has provided a benefit program with real financial value. Your benefits package will improve your life and the lives of your family members.

A great deal of time and effort has been invested in designing, funding, and maintaining a quality benefit plan. You and your family can also play an important role in getting the most from your benefits by making sure that you understand them.

select your benefits carefully ...

When possible, you are offered options so that you can select the plan that best fits your needs. To get the most value from your benefits, carefully consider which options are right for you and your family. Because your premiums are generally deducted on a pre-tax basis, IRS regulations may prohibit you from making enrollment changes until the end of the plan year, unless you experience a family status change. For instance, you may not be able to cancel your coverage if you believe you will no longer be using the plan for the rest of the year. Please check with Human Resources if you are considering enrolling in coverage or terminating coverage before the plan year ends.

inside this booklet ...

This booklet describes your 2025 employee benefits under the City of Anoka benefit package. For each type of coverage, you will find a description of the coverage, as well as information about eligibility, enrollment, costs, and contact information. For some benefits, you will also find an insert directly from the insurance carrier that describes the coverage in more detail.

This booklet is intended to provide a summary of each of your benefit plans. Although care was taken to correctly describe these plans, you should consult your actual certificate of coverage for full details. If you have dependents who are enrolled in coverage, make sure that they have the opportunity to review this information as well.

Medical Benefits

overview ...

The following pages are intended to provide a brief overview of your medical insurance. Carefully review the benefit inserts which follow for details about the plan options that are available to you. To determine which plan is best for you and your family, consider each plan's network design, deductible, co-pays, coinsurance, and monthly costs.

What is the name of our Medical Plan?	You can choose between these HealthPartners plans: $3,300-100% Open Access $3,300-75% Open Access $5,000-100% Open Access $3,300-100% Achieve $3,300-75% Achieve $5,000-100% Achieve
When does coverage begin?	Coverage begins on the first day of full-time employment.

Employee Monthly Plan Costs...

	$3,300-0% Open Access	$3,300-75% Open Access	$5,000-0% Open Access	$3,300-0% Achieve	$3,300-75% Achieve	$5,000-0% Achieve
Employee	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Employee + Spouse	$601.24	$432.16	$431.44	$491.48	$332.55	$331.87
Employee + Child(ren)	$499.53	$346.15	$345.49	$399.96	$255.78	$255.16
Family	$773.06	$643.64	$542.66	$624.13	$408.49	$407.56

City of Anoka Monthly Plan Costs...

	$3,300-0% Open Access	$3,300-75% Open Access	$5,000-0% Open Access	$3,300-0% Achieve	$3,300-75% Achieve	$5,000-0% Achieve
Employee	$870.75	$790.27	$789.92	$818.50	$742.85	$742.52
Employee + Spouse	$1,228.00	$1,228.00	$1,228.00	$1,228.00	$1,228.00	$1,228.00
Employee + Child(ren)	$1,160.00	$1,160.00	$1,160.00	$1,160.00	$1,160.00	$1,160.00
Family	$1,709.00	$1,709.00	$1,709.00	$1,709.00	$1,709.00	$1,709.00

City of Anoka HSA Contributions...

	January 1, 2025 Lump Sum	July 1, 2025 Lump Sum
Employee	$900	$900
Employee + Spouse	$900	$900
Employee + Child(ren)	$900	$900
Family	$900	$900

HSA Contribution details:

Total HSA contribution amount will be prorated by months for any new hires

Medical Insurance Cont.

online features ...

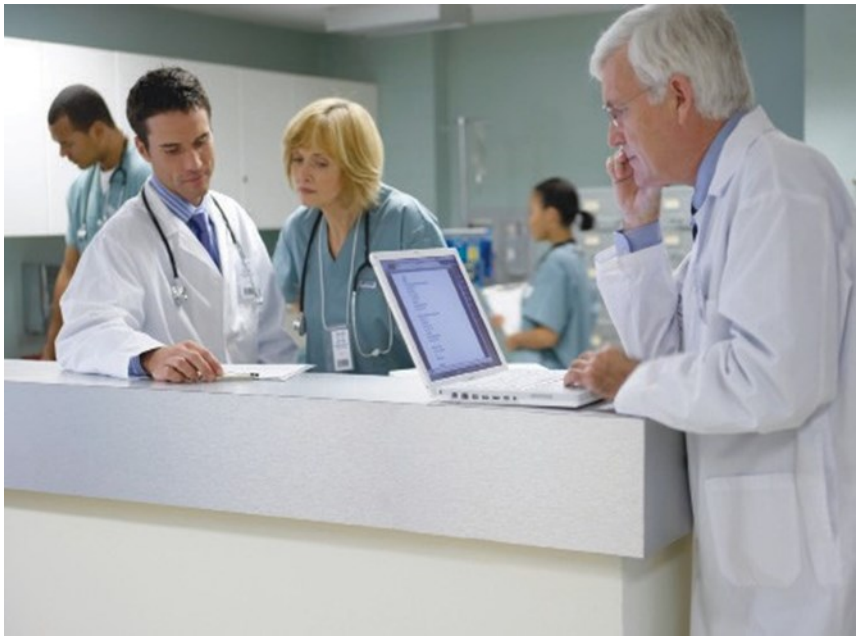
Register at **www.healthpartners.com** to gain access to a variety of resources.

- Summary of Benefits and Coverage
- Claims/Explanation of Benefits
- Search for a provider
- Health discounts and special programs
- Additional health resources and links
  *On your first visit, you will need to create a username and password.

finding a network provider...

Remember that you pay less when you seek care within the network. To find a network provider:

- Log onto www.healthpartners.com. Under “Insurance” click on, “Explore as a guest.” Then click “I get insurance through work.” Then under “Medical plan networks,” choose either “Open Access Network” or “Achieve Network.”
- Call HealthPartners Member Services at 952-883-5000, or call our sales team at 800-298-4235 if you’re not a member.



HSA Plan

overview ...

A Health Savings Account (HSA) in conjunction with a compatible High-Deductible Health Plan (HDHP) is a new way to secure more affordable health coverage for you and your family and to save on taxes. Flexible, affordable and easy to use, an HSA empowers you to take charge of your health, your money and your future.

You decide how much money (certain limitations apply) you want to contribute each year. Higher contribution limits, allowable catch-up contributions and the ability to save money for future healthcare expenses, make the HSA more flexible than other tax-advantage accounts.

Who administers our HSA plan?	Optum Bank
When does coverage begin?	As soon as you enroll in the HealthPartners High Deductible Health Plan (HDHP) you are eligible to establish your HSA. Please see the medical section for eligibility guidelines on your medical plan.
What is the maximum amount I can elect to put into my HSA?	Refer to the "Contributing to your HSA" section on the following page for more details.
Will my employer be making a contribution into my HSA?	Yes, the City of Anoka will contribute $1,800 annually for single coverage, Employee + Spouse, Employee + Child(ren) coverage, and family coverage if enrolled in the HDHP.
Can I stop or change my contributions?	Yes, you can stop or change your contributions by completing the necessary Optum Bank documents and submitting them to your HR Department.

** The City will contribute 50% on January 1, 2025, and the remaining 50% will be deposited on July 1, 2025.

Employee needs to be actively employed to be eligible for the second half of the City's Contribution on July 1st. Employees beginning employment July 2 or later, are only eligible for 50% of the City's 2nd contribution amount.

Employees who are actively employed between January 1 and July 1 will receive $1,800 city contribution to their HSA account for the year. The first payroll following January 1 and July 1, the city will deposit $900 to their HSA account.

Employees who begin employment between July 2 and December 31 will receive $900 city contribution to their HSA account on the first payroll following their employment start date.

HSA Plan Cont.

how it works …

Participating in an HSA:
To participate in an HSA, you must be enrolled in a High Deductible Health Plan (HDHP. A HDHP is a comprehensive health plan with an annual deductible of at least $1,650 for an individual and $3,300 for two or more family members.

Contributing to Your HSA:
When you participate in an HDHP, you set aside money to pay for eligible out-of-pocket health care expenses. Money can be contributed to your HSA by you and/or your employer, up to a maximum of $4,300 single/$8,550 family for 2025. There are no vesting requirements or forfeiture provisions. Unlike flexible spending accounts, HSA plans do not have a “use it or lose it” requirement. Your account balance rolls over from year to year and may earn interest tax-free.

If you are age 55 or older, you can make an additional contribution amount up to $1,000 in 2025. Contributions to your HSA account are tax deductible (tax-deferred, if made by your employer), and withdrawals are not taxed as long as they are used to pay for qualified medical expenses.

Investing Your Money:
Federal law requires that contributions be deposited with a qualified trustee or custodian. A qualified custodian holds your HSA contributions exclusively for your benefit, ready for you to use whenever you may have qualified medical expenses to pay. You may have the opportunity to invest the balance of your HSA.

Using your HSA:
Money in your HSA plan can be used to pay for a variety of health care related expenses ranging from dental or vision expenses to prescription drugs. Keeping track of your account balance is easy. You can review your account information 24/7 by logging onto your administrator’s website.
Your HSA money is tax-free as long as it is used to pay for qualified medical expenses. If you use the money for any other reason, you will be required to pay income tax and a 20% tax penalty on that amount (you will not pay a penalty if you are disabled or age 65 or older. It is your responsibility to keep supporting documents to show the IRS you used the funds to pay for qualified medical expenses.

HSA Plan Cont.

frequently asked questions ...

If you are interested in participating in an HSA, you are encouraged to contact your own tax advisor for specific advice.
It is also recommended that you read the IRS document (as well as other guidelines) available online at www.treas.gov/offices/publicaffairs/hsa/index.html

What types of insurance and other coverage can I have and still be eligible to take advantageof an HSA?	Permitted insurance includes: workers' compensation; property insurance; insurance for a specificdisease, such as cancer coverage; and insurance that pays a fixed amount per day of hospitalization. Coverage for dental, vision, long- term care, accidents, and disabilityare also permitted.
Can I use the money in my HSA account to pay for medical insurance premiums?	Generally, you cannot use your HSA account to pay for health insurance premiums. Exceptions include COBRA premiums, long-term care premiums, or premium payments that allow you to retain health coverage while you are receiving unemployment compensation.
What is a qualified medical expense?	Qualified medical expenses are services that are typically covered by a healthcare plan, such as officevisits, ER services, and hospitalization. Qualified medical expenses also include: prescription drugs; vision expenses - including eyeglasses and contact lenses; medical plan deductibles and copays; as well as non-cosmetic dental expenses. The covered items are defined by the IRS code 213(d) and are listed in IRS publication 502.
What if I use my HSA to pay for something other than a qualified medical expense?	You will need to include that amount in your gross income when you file your taxes. It will betreated as regular income, and if you are less than age 65, it will be subject to a 20% excise tax.

Dental Insurance

overview ...

Although dental services are usually less costly than medical services, dental insurance is still important to provide financial assistance to you and your family to meet general dental care needs. Your plan is designed to encourage regular visits to your dentist, which are essential to maintaining oral health, and to provide coverage for basic diagnostic and preventive dental needs.

What is the name of our Dental Plan?	You have the Delta Dental Millennium Choice Plan.
When does coverage begin?	Coverage begins on the first of the month following your date of hire.
What benefits are provided?	Please refer to the benefit summary which follows.

The following pages are intended to provide a brief overview of your dental insurance. Please review the dental benefit insert(s) carefully to better understand your benefits under this plan.

monthly plan costs ...

	Employee Cost
Employee	$52.06
Employee + 1	$104.13
Employee + Child(ren)	$135.50
Family	$171.38

* Please note that if you do not enroll into this Dental Plan when you are first eligible, you may not be able to enroll at a later date or may be subject to late entrant waiting periods. Please consult your HR Department for more information.

online features ...

Register at **www.deltadentalmn.org** to gain access to a variety of resources.

- Claims
- Your benefit information
- Search for a provider
- Additional health resources and links

  *On your first visit, you will need to create a username and password.

finding a network provider ...

Remember that you pay less when you seek care within the network. To find a network provider:

- Log onto www.deltadentalmn.org and click on “Find a Dentist.” Under “Network” choose “Delta Dental PPO” or “Delta Dental Premier.” Enter a providers last name or search within a certain amount of miles from your home zip code.
- Call Delta Dental Member Services toll free at 1-800-448-3815. Call center is open from 1AM—7PM CST.

Delta Dental PPO™ plus Premier®
Dental Solutions – Dual Option with Orthodontic
Summary of Dental Plan Benefits

	Option 1		Option 2
	Delta Dental PPO™ Dentist	Delta Dental Premier®/Non-Participating Dentist	Delta Dental Premier®/Non-Participating Dentist
Service Type	Plan Pays	Plan Pays	Plan Pays*
Diagnostic & Preventive			
Diagnostic and Preventive Services – exams, cleanings, and fluoride	100%	80%	100%
Radiographs – X-rays	100%	80%	100%
Periodontal Maintenance – cleanings following periodontal therapy	100%	80%	100%
Space Maintainers – appliances to prevent tooth movement	100%	80%	100%
Basic Services			
Sealants – to prevent decay of permanent teeth	90%	50%	80%
Emergency Palliative Treatment – to temporarily relieve pain	90%	50%	80%
Minor Restorative Services – fillings	90%	50%	80%
Simple Oral Surgery	100%	50%	80%
Anesthesia Services – when medically necessary	90%	50%	80%
Other Basic Services – misc. services	90%	50%	80%
Major Services			
TMJ Treatment – treatment of the disorder of the temporomandibular joint and craniomandibular disorder, including related films	80%	80%	80%
Crown Repair – to individual crowns	50%	50%	50%
Endodontic Services – root canals	80%	50%	50%
Periodontic Services – to treat gum disease	80%	50%	50%
Oral Surgery Services – extractions and dental surgery	80%	80%	80%
Major Restorative Services – crowns	50%	50%	50%
Relines and Repairs – to bridges, implants, and dentures	50%	50%	50%
Prosthodontic Services – bridges, implants, and dentures	50%	50%	50%
Annual Deductible - Per person/per family	$0	$25/$75	$25/$75
Annual Maximum – Per person/per calendar year	$2,000	$2,000	$1,000
Orthodontic Services			
Orthodontic Services – Braces	50%	50%	50%
Orthodontic Age Limit -	Dependent Children from the age of 8 up to age 19	Dependent Children from the age of 8 up to age 19	Dependent Children from the age of 8 up to age 19

*When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. The Nonparticipating Dentist Fee may be less than what the dentist charges and you are responsible for that difference.

Coverage Year – Your coverage year is January 1 through December 31

Posterior resin fillings are covered without alternation to amalgam allowance.

Option1: PPO - $0 deductible, Premier/OON - $25 Deductible is applicable per person per Coverage Year limited to a maximum Deductible of $75 per family per Coverage Year. The Deductible does not apply to oral exams, preventive services, X- rays, periodontal maintenance, and cephalometric films, and orthodontic services.

Option 2: $25 Deductible is applicable per person per Coverage Year limited to a maximum Deductible of $75 per family per Coverage Year. The Deductible does not apply to oral exams, preventive services, X- rays, periodontal maintenance, and cephalometric films, and orthodontic services.

Option 1: Annual Maximum – $2,000 per person total per Coverage Year on all services.

Option 2: Annual Maximum - $1,000 per person total Coverage Year on all services.

Orthodontics, is subject to a separate lifetime maximum of $1000 per Covered Person and limited to those orthodontic treatment plans commenced on or after the Eligible Dependent Child's eighth (8th) birthday and prior to the Dependent Child's nineteenth (19th) birthday.

Payment for Orthodontic Service – Because orthodontic treatment normally takes place over a long period of time, payments for benefits are made over the course of treatment. The Covered Person must continue to be eligible under the Plan in order to receive ongoing payments for orthodontic benefits. Delta Dental will make an initial payment to you or your Participating Dentist equal to Delta Dental's stated Copayment on 30% of the Maximum Payment for Orthodontic Services as set forth in this Summary of Dental Plan Benefits when treatment begins (appliances are installed). Delta Dental will make additional payments as follows: Delta Dental will pay the remaining 70% of the Maximum Payment for Orthodontic Services in 8 (eight) quarterly payments after your benefits and eligibility have been verified at the time of payment.

Orthodontics must be performed and supervised by a licensed dentist or orthodontist who has established the need for such procedures through a complete in-person oral examination, and has developed a proper treatment plan through adequate diagnostic activities, including radiographic imaging.

Long-Term Disability Insurance

overview ...

What is the name of our LTD carrier?	New York Life
When does coverage begin?	Coverage begins on the first of the month following 6 months of full-time employment.
What benefits are provided?	Your long-term disability benefitis equal to 60% of your monthly earnings, to a monthly maximum of $7,000. Benefits are paid after 60 days of disability.
How are pre-existing conditions covered?	You have a pre-existing condition if you received medical treatment, consultation,care or services including diagnostic measures, or took prescribed drugs or medicines inthe 3 months just prior to your effective date of coverage, and the disability begins in the first 12 months after your effective date ofcoverage. Your plan does not cover a disability caused by a pre-existing condition.

monthly plan costs ...

The monthly premium for your long-term disability is paid by the City of Anoka.

Life Insurance

Your life insurance benefits are intended to protect your family's financial security in the event of your death. Regardless of your age, income, or health status, life insurance will help secure the future of your survivors.

Remember that your life insurance benefits also include Accidental Death and Dismemberment benefits. If you should die in an accident, your plan will pay an increased benefit.

When you enroll in the life insurance plan, you need to designate a beneficiary who will receive the benefit in the event of your death. Since the most current beneficiary form on file determines who will receive your benefit, it is important to review your beneficiary election from time to time. You can change your beneficiary at any time by completing a new form and returning it to your employer.

overview ...

What is the name of our carrier?	New York Life
What is our policy number?	Basic & Vol Life SGM611963—Basic and Vol AD&D SOK608998
When does coverage begin?	Coverage begins on the first dayof full-time employment.
What benefits are provided?	Your plan provides a Life and Accidental Death and Dismemberment benefit of $35,000.
Is there an age reduction schedule?	At age 65, benefit reduces to 65%; at age 70, benefit reduces to 50%; and at age 75, benefit reduces to 30% of the original amount. Benefits terminate upon your retirement or if you leave employment with the city.
Is there a conversion privilege?	This is included in your coverage.

monthly plan costs …

The monthly premium for your life insurance is paid by City of Anoka.

Voluntary Life Insurance

overview ...

What is the name of our carrier?	New York Life
When does coverage begin?	Coverage begins on the first day of full-time employment.
What coverage is available?	Life and AD&D coverage is available for you and your spouse. You may elect voluntary life and AD&D coverage in increments of $10,000 with a minimum amount of $20,000, and a maximum of $500,000 or 5x your salary. You may elect voluntary life and AD&D coverage for your spouse in increments of $10,000 to a maximum of 50% of the benefit elected for yourself. Life insurance is available for your children. You may elect voluntary life coverage for dependent children in increments of $5,000 to a maximum of $10,000. From Birth to 6 months old, children have a limited benefit available of $500.
What is Guarantee Issue?	Guarantee Issue is the amount of insurance you can purchase without completing medical questions. Guarantee Issue is only available if you enroll when you are first eligible (at new hire). The guarantee issue amount for employee coverage is the lesser of $100,000 or 5x your salary. The guarantee issue amount for spouse coverage is $20,000.

The Voluntary Life and AD&D coverage is 100% paid by the employee. Please see Human Resources for more information on monthly premiums.

Flexible Spending Account

Your out-of-pocket healthcare and dependent care expenses can add up quickly. Healthcare and dependent care expenses are only partially tax deductible, if at all. Ordinarily, these expenses are paid with after-tax dollars. When you enroll in a flexible spending plan, you can pay for these expenses using pre-tax salary dollars not subject to Social Security (FICA) and applicable federal or state income taxes. The money you set aside in your flexible spending account is excluded from your taxable income.

It is easy to save tax dollars through your flexible spending account. If you are currently paying a portion of your medical and/or dental premiums, this amount will automatically be deducted from your paycheck on a pre-tax basis unless you notify your Human Resources Department in writing that you do not want to participate.

for which account(s) am I eligible?

Healthcare Spending Account: Medical, dental, and vision expenses are covered with this account. ***You cannot participate if you are enrolled in an HSA.***

Limited Flex Account: Dental and vision expenses are covered with this account. ***This account is for employees who are enrolled or have spouses who are enrolled in an HSA plan.***

Dependent Care Reimbursement Account: Daycare expenses are covered with this account. ***Anyone with eligible dependents may participate in this plan.***

What is the name of our carrier?	Benefit Extras
When does coverage begin?	Coverage begins on the first day following one full pay period.
What is our plan year?	Your plan year runs from January 1st through December 31st each year.
What is the maximum amount I can elect to put into my flex account?	The maximum Healthcare Account and Limited Flex Account election is $3,300 per year. The maximum Dependent Care Account election is $5,000 per year ($2,500 if married filing a separate tax return) or the lesser of you or your spouse's earned income. This maximum is set by the IRS.
How often do I need to enroll?	Because expenses vary from year to year, you must re-enroll each year if you choose to participate in this plan.

Flexible Spending Plan Cont.

how to participate ...

- To help determine your election amount, you can estimate your annual out-of-pocket expenses for your Health- care Spending Account, Limited Flex Account and/or Dependent Care Account. Please refer to the following pages for more information on eligible expenses and for worksheets to help estimate your costs.
- The money you elect is automatically deducted from your salary in equal installments and deposited in your flexible spending account before federal, state, and FICA taxes are withheld.
  Note: any reduction in your taxable income may also lead to a reduction in future Social Security benefits. For most employees, this reduction is insignificant compared to the tax savings of a flexible spending plan.
- As you incur medical or dependent care expenses, complete a claim form and submit it to Benefit Extras. After your claim is processed you will be reimbursed.
- Expenses must be incurred during the plan year, however you may continue to submit claims for up to 90 days after the end of the plan year. Note: any unused funds in your account are forfeited. There is no rollover provision at this time.

restrictions ...

Because of the tax advantages of a flexible spending account, the IRS has established rules involving the use of your account. Keep these restrictions in mind when planning for and enrolling in the flexible spending account.

- You may only enroll upon eligibility or at the beginning of the plan year.
- Once enrolled, you may not make changes to your elections unless you experience a family status change, such as marriage, birth, adoption, divorce, death, or loss of spouse's employment. See your HR Department for more details on eligible family status changes.
- Any unused or unclaimed money left in your flexible spending account at the end of the plan year will be forfeited. For this reason, plan carefully and only contribute those dollars that you are reasonably sure you will spend.

eligible expenses ...

Your expenses must meet certain IRS criteria to be eligible for reimbursement. Please use these guidelines to help you determine which expenses are eligible.

Healthcare Spending Account expenses:

- Expenses (medical, dental, and vision) that are medically necessary. This means the expense must be for the diagnosis, treatment or prevention of disease.
- Expenses that are not reimbursable from any other health insurance or reimbursement program.
- Expenses for cosmetic procedures that are not medically necessary are not eligible.

Limited Flexible Spending Account expenses:

- Expenses (dental and vision only) that are medically necessary. This means the expense must be for the diagnosis, treatment or prevention of disease.
- Expenses that are not reimbursable from any other health insurance or reimbursement program.

Dependent Care Reimbursement Account expenses:

- To be considered a "dependent," the person receiving care must be eligible to be claimed as your dependent on your federal income tax return, and be either under the age of 13, your spouse, or other dependent who is physically or mentally incapable of self-support and spends at least eight hours per day in your home.
- You must incur this dependent care expense due to work. If married, both you and your spouse must be working, or your spouse must be a full-time student or disabled.
- For tax purposes, you must provide tax ID numbers from your daycare center or private provider.
- Your provider cannot be one of your children unless they are 19 years of age or older.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

WHAT IS A HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

A Health Care Flexible Spending Account allows you to set aside tax-free money to cover eligible health care expenses you incur for you and your eligible dependents during the plan year. Eligible dependents include your spouse and your adult child who as of the end of the taxable year has not attained age 27 and regardless of whether or not this individual is a full-time student, disabled or married. **By participating in a Health Care Flexible Spending Account, you and/or your spouse are disqualified from contributing to a Health Savings Account.**

ELIGIBLE HEALTH CARE (MEDICAL/DENTAL) EXPENSES

Eligible health care (medical/dental) expenses are expenses that are "medically or dentally necessary." This means the expenses must be for the diagnosis, treatment or prevention of disease and for treatment affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. In addition, to qualify as a reimbursable health care expense the medical, dental, vision or hearing expense must:

- be incurred (received) during your eligible period of coverage; and
- not be reimbursable from any other health insurance or reimbursement program.

Expenses incurred prior to the plan year start date or prior to your effective date are not eligible for reimbursement. Expenses incurred after your termination of employment or after the plan year end date are also not eligible for reimbursement. Certain plans may include a grace period. Please refer to your plan documents.

The IRS imposes certain restrictions on Health Care Flexible Spending Accounts, including the following:

- Authorized salary reductions into your Health Care Flexible Spending Account may not be changed for the rest of the year unless you terminate employment or have a change in family status. Changes in family status are discussed in your Summary Plan Description.
- You will forfeit all unused funds in your Health Care Flexible Spending Account at the end of the plan year. ***This is the "use it or lose it" rule***. Unused balances may not be carried over to the next plan year or converted to cash. For this reason, you should estimate your anticipated expenses for the plan year conservatively.
- You will receive a statement shortly after the start of the plan year. Here you will receive information as to how to log on to our website and view your account information. As indicated above, these amounts must be used by the end of the plan year or during the grace period or they will be lost (refer to your Highlight Sheet or SPD to determine whether a grace period is provided). You may continue to submit claims up to 90 days after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given **90** days from their date of termination in which to submit expenses incurred prior to their termination.

LIMITED HEALTH CARE FLEXIBLE SPENDING ACCOUNT

WHAT IS A LIMITED HEALTH CARE FLEXIBLE SPENDING ACCOUNT?

A Limited Health Care Flexible Spending Account works like the Health Care Flexible Spending Account described previously but only covers eligible dental, vision and post-deductible expenses for you and your dependents **(any medical expenses including over-the-counter drugs are NOT eligible under this Account)**. Post-deductible expenses are expenses for medical care which are incurred after the minimum annual deductible applicable to "high deductible health plans" under Code Section 223 have been satisfied. Eligible dependents include your spouse and your adult child who as of the end of the taxable year has not attained age 27 and regardless of whether or not this individual is a full-time student, disabled or married. If you participate in the Limited Health Care Flexible Spending Account, you may also contribute to a Health Savings Account, if you are otherwise eligible. Note that you may participate in either the Limited Health Care Flexible Spending Account or the Health Care Flexible Spending Account, but not both.

ELIGIBLE HEALTH CARE EXPENSES

Eligible expenses under the Limited Health Care Flexible Spending Account are dental, vision and post- deductible expenses that are "medically or dentally necessary." This means the expenses must be for the diagnosis, treatment or prevention of disease and for treatment affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. Post-deductible expenses are expenses for medical care which are incurred after the minimum annual deductible applicable to "high deductible health plans" under Code Section 223 have been satisfied.

In addition, to qualify as a reimbursable dental, vision or post-deductible expense, the expense must:

- be incurred (received) during your eligible period of coverage; and
- not be reimbursable from any other health insurance or reimbursement program.

Expenses incurred prior to the plan year start date or prior to your effective date in the plan are not eligible for reimbursement. Expenses incurred after your termination of employment or after the plan year-end date are also not eligible for reimbursement. Please check your Highlight Sheet or your SPD to determine if your plan offers the grace period.

The IRS imposes certain restrictions on Limited Health Care Flexible Spending Accounts, including the following:

- Authorized salary reductions into your Limited Health Care Flexible Spending Account may not be changed for the rest of the year unless you terminate employment or have a change in family status. Changes in family status are discussed in your Summary Plan Description.

- You will forfeit all unused funds in your Limited Health Care Flexible Spending Account at the end of the plan year or, if part of the Plan, the corresponding grace period (refer to your Highlight Sheet or SPD to determine whether a grace period is provided). ***This is the "use it or lose it" rule***. Unused balances may not be carried over to the next plan year or converted to cash. For this reason, you should estimate your anticipated expenses for the plan year conservatively.

- You will receive a statement shortly after the start of the plan year. Here you will receive information as to how to log onto our website and view your account information. As indicated above, these amounts must be used by the end of the plan year or during the grace period or they will be lost (refer to your Highlight Sheet or SPD to determine whether a grace period is provided). You may continue to submit claims up to 90 days after the Plan Year ends for prior year's expenses. Employees who terminate employment during the Plan Year will be given 90 days from their date of termination in which to submit expenses incurred prior to their termination.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

One of the most important issues to a working parent is childcare. Not only is it difficult to find and arrange for good childcare, it can be very expensive. Also, with our aging population, many people are caring for elderly or disabled dependents that are unable to care for themselves.

WHAT IS A DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT?
The Dependent Care Flexible Spending Account is designed to give you a tax saving way to pay for these expenses. This account works much like the Health Care Flexible Spending Account – with a few twists.

It is important to remember that the dependent day care expenses must meet certain IRS requirements. The expenses must be necessary for you to continue working. If married, you and your spouse must both be working, or your spouse must be a full- time student or disabled.

To be considered a "dependent," the person receiving care must be eligible to be claimed as your dependent on your federal income tax return and be either:

- under the age of 13; or
- your spouse or other dependent who is physically or mentally incapable of self-support, and who spends at least 8 hours per day in your home.

USING TAX-FREE DOLLARS TO PAY FOR EXPENSES
With a DCRA you can set aside money to cover these expenses on a tax-free basis. This way you save money because you never have to pay taxes on the money you set aside in the account. For example, if you incur $2,000 of eligible dependent (day) care expenses in a year, you could save about $603 in income taxes:

REIMBURSABLE DEPENDENT (DAY) CARE EXPENSES

To qualify as a reimbursable dependent (day) care expense, the expense must be incurred during the plan year. Any dependent (day) care expenses incurred prior to the plan year are not reimbursable.

SETTING UP AN ACCOUNT

To set up a Dependent Care Flexible Spending Account, you must first decide how much money to set aside for the plan year. You may deposit any amount up to $416 a month ($5,000 annually for a full plan year). Your maximum amount is $208 a month if you are married filing a separate income tax return. The IRS limits the amount of money you may redirect to the smallest of:

- your income,
- your spouse's income, or
- $5,000 per family ($2,500 if married filing separate returns).

There are special IRS provisions if your spouse is a full-time student or is disabled.

SPECIAL NOTICE CONCERNING DEPENDENT CARE EXPENSES

Under current law, a tax credit is available for dependent day care expenses of the same type eligible for reimbursement through the Plan. The amount of the credit depends on the taxpayer's adjusted gross income and ranges from 20% to 35% of eligible expenses up to a limit of $3,000 of expenses if there is one eligible Dependent and $6,000 of expenses if there are two or more eligible Dependents. You will not be eligible to take the tax credit for any expenses reimbursed through the Plan. In addition, the maximum amount of expenses eligible for the credit will be reduced on a dollar-for-dollar basis for each dollar of dependent day care reimbursements you receive under the Plan.

Determining whether taking the credit or reimbursement under the Plan is more beneficial involves complex calculations. Because each individual's situation is different, the Employer cannot predict whether or not it would be more beneficial for you to take the tax credit for dependent day care expenses or to have your expenses reimbursed under the Plan. You may want to consult your tax advisor to determine whether the tax credit or Dependent Care Flexible Spending Account is more beneficial to your personal situation.

HEALTH CARE AND DEPENDENT CARE ACCOUNT WORKSHEET

The purpose of this worksheet is to determine the medical, dental, vision or dependent care (day care) expenses for which you are not reimbursed from any other benefit plan. Be conservative and estimate only those expenses you are reasonably certain you will incur during the plan year. Under the ***"Use or Lose"*** provisions, if you allocate too much money to your account and cannot use the money by the end of the plan year or, if part of the Plan, the corresponding grace period (refer to your Highlight Sheet or SPD to determine whether a grace period is provided), you forfeit the remaining balance.

ESTIMATED UNREIMBURSED HEALTH CARE EXPENSES

	Annual Amount
Medical Deductibles/Co-payments	_____
Medical Supplies (Prescribed by physician)	_____
Other Medical Providers (Chiropractic, podiatrists, etc.)	_____
Over the counter medications	_____
Dental Deductibles/Co-payments	_____
Dental Expenses (Exams, cleaning, fillings, etc.)	_____
Prescription Drug Deductibles/Co-payments	_____
Vision Care (Eye exams, contacts, eye glasses)	_____
Orthodontia	_____
Any Other Eligible Expenses	_____
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR	_____
NUMBER OF PAY PERIODS IN THE PLAN YEAR (or partial year, if applicable)	_____
DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS	_____ *

*Enter the result on the enrollment form under either the Health Care or Limited Health Care Flexible Spending Account Elections PER PAY PERIOD amount. You may participate in either the Limited Health Care Flexible Spending Account or the Health Care Flexible Spending Account, but not both. **IMPORTANT NOTE:** The Limited Health Care Flexible Spending Account will only reimburse you for eligible dental, vision & post-deductible expenses, which you need to consider when making your projections.

ESTIMATED DEPENDENT CARE (DAY CARE) EXPENSES

	Annual Amount
Day Care for Eligible Dependents	_____
Pre-School Educational Programs	_____
TOTAL PROJECTED EXPENSES FOR THE PLAN YEAR	_____
NUMBER OF PAY PERIODS IN THE PLAN YEAR (or partial year, if applicable)	_____
DIVIDE PROJECTED EXPENSES BY # OF PAY PERIODS	_____**

**Enter result on the enrollment form under Dependent Care Account Elections PER PAY PERIOD amount.

Please Note: You can only change your election(s) during the Plan Year if you experience a change in family status. Consult the Plan Document or Summary Plan Description for more details.

Glossary of Important Insurance Terms

The key to making the most of your insurance is to make sure that you understand it. On this page, you will find some important and commonly used insurance terms that may help you understand your plan(s). For more information, you may also refer to your Certificate(s) of Coverage.

Beneficiary: A person(s) or trust you designate to receive benefits (usually for a life insurance policy) in the event of your death. You may change your beneficiary at any time by submitting a new beneficiary designation form available from your employer.

Certificate of Coverage: A certificate provided by your insurance company that explains exactly what is and is not covered by your insurance plan. Refer to your certificate of coverage for the most complete information about your insurance plan.

COBRA (Continuation of Coverage): A federal law that requires most employers to offer employees and their families the opportunity for a temporary extension of coverage at group rates in certain instances where coverage under the plan would otherwise end. Please refer to the "Important Benefit Information" section in this packet for a copy of your COBRA rights.

Coinsurance: This means that healthcare fees are shared between you and the insurance company. Coinsurance is usually a pre-determined percentage of each service.

Coordination of Benefits: If you are covered by more than one medical or dental plan, your insurance companies will set out rules to deter- mine how to coordinate benefits when a claim is received. The companies will determine which plan pays primary and which plan pays secondary, up to 100% of the total allowable expenses.

Copayment (Copay): A fixed amount that your medical insurance company determines you will pay each time you utilize a certain service.

Deductible: For some plans, you pay a certain amount of money out of pocket each year for covered services before your benefits begin. This amount you pay is your deductible.

EOB (Explanation of Benefits): A report that explains how your medical or dental insurance claim was processed. The report usually shows the date of service, the provider, the amount of the claim, the amount of any copayment, coinsurance, or deductible, and the provider discount. Remember that this is not a bill.

Formulary Drugs: A drug formulary is a list of generic and brand name drugs that have been evaluated for safety and effectiveness, which your insurance company considers "best choices." Some medical plans provide coverage for formulary drugs only, while others provide formulary drugs at a lower cost.

Generic Drugs: Generic drugs are drugs that are equal to brand name drugs in safety and effectiveness, but are much less expensive. The FDA requires that generic drugs be "bio-equivalent" to the brand name version, meaning the drugs have the same active ingredients, in the same dosage, form and strength.

Guarantee Issue: Guarantee Issue is the amount of coverage (usually voluntary life insurance) that the insurance company guarantees to provide without requiring medical questions and underwriting.

Network Provider: A healthcare provider or group of healthcare providers who contract with your insurance company to provide services for a pre-determined fee. You will avoid Usual and Customary charges when you see a network provider. Most plans also provide a higher level of coverage when you see network providers.

Open Access Network: With an open access network, you are free to see any provider within that network from which you need healthcare services. There is no need to designate a primary care clinic or get a referral to see a specialist.

Open Enrollment: Most insurance plans run on a year-long basis, meaning that after a year, your insurance plan is up for renewal. During this time, you may be able to join a plan, make benefit election changes, switch to a different plan, or add dependents to a plan without a qualifying event.

Out-of-Pocket: The actual dollars you pay for your healthcare services "out of your pocket." Co- pays, deductibles and coinsurance are typical out- of-pocket costs. If you reach your out-of-pocket maximum for the year, your insurance company pays 100% of your remaining eligible expenses. Non-covered, ineligible expenses do not count toward your out-of-pocket maximum.

Pre-Existing Condition: Although exact definitions vary according to each plan, a pre-existing condition is generally defined as a medical condition you had before you became covered under the plan, and may be excluded from coverage or require a waiting period be- fore being eligible for coverage. Consult your Certificate of Coverage for specific details.

Pre-Treatment Estimate: You may request a pre-treatment estimate on any anticipated dental treatment. Ask your dental provider to describe the proposed treatment and charges on a claim form and submit the form to your insurance carrier for review. The carrier will notify your dentist of how much of the treatment will be covered. Pre-treatment estimates are recommended to avoid any surprises and to allow you to plan accordingly.

Primary Care Network: With this network, you are required to designate a primary care provider or clinic upon enrollment to coordinate your healthcare needs. If specialized care is needed, you must receive a referral from your primary care provider in order to receive network benefits.

Primary Care Provider: A general practice doctor who sees you over an extended period of time. Primary care providers are usually familiar with your health history and are able to refer you to a specialist if specialized care is needed.

Usual and Customary (U&C): The usual fee that is charged by most providers within your geographic area for a particular service and that your insurance company determines is the "allowed amount" they will pay for that service. If you see a non-network provider, you are responsible for paying the difference between the usual and customary amount allowed by your insurance company and the non-network provider charges.

Qualifying Event: Once you enroll, you generally cannot change your elections until the next annual open enrollment period. However, if you have a qualifying event, you may be able to make election changes. Events such as birth, adoption, death, marriage, divorce, or significant changes in employment status may allow you to make changes. Contact your employer or consult your Certificate of Coverage for specific details.

Patient Protections Disclosure

The City of Anoka generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation HealthPartners, Inc. designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the HealthPartners, Inc. at 800.883.2177 or www.healthpartners.com

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from HealthPartners, Inc. or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HealthPartners, Inc. at 800.883.2177 or www.healthpartners.com

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: $3,300 HSA -100% Open Access Network Plan (Individual: 0% coinsurance and $3,200 deductible; Family: 0% coinsurance and $6,600 deductible)

Plan 2: $3,300 HSA - 75% Open Access (Individual: 25% coinsurance and $3,300 deductible; Family: 25% coinsurance and $6,600 deductible)

Plan 3: $5,000 HSA - 100% Open Access (Individual: 0% coinsurance and $5,000 deductible; Family: 0% coinsurance and $10,000 deductible)

Plan 4: $3,300 HSA - 100% Achieve (Individual: 0% coinsurance and $3,200 deductible; Family: 0% coinsurance and $6,600 deductible)

Plan 5: $3,300 HSA - 75% Achieve (Individual: 25% coinsurance and $3,300 deductible; Family: 25% coinsurance and $6,600 deductible)

Plan 6: $5,000 HSA - 100% Achieve (Individual: 0% coinsurance and $5,000 deductible; Family: 0% coinsurance and $10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 763.576.2712 or aoehlers@ci.anoka.mn.us.

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)

IIf 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, 2024. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	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
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/ flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**INDIANA – Medicaid**
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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – 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://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	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)

To see if any other states have added a premium assistance program since July 31, 2024, 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 1/31/2026)

HIPAA Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights

City of Anoka is committed to the privacy of your health information. The administrators of the City of Anoka 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 Amy Oehlers - Assistant City Manager at 763.576.2712 and aoehlers@ci.anoka.mn.us.

HIPAA Special Enrollment Rights

City of Anoka Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the City of Anoka 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 30 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 30 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 Amy Oehlers - Assistant City Manager at 763.576.2712 or aoehlers@ci.anoka.mn.us.

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 City of Anoka

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 City of Anoka 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. **City of Anoka 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 City of Anoka coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current City of Anoka coverage, be aware that you and your dependents may not be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with City of Anoka 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 City of Anoka 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, 2025**
Name of Entity/Sender:	**City of Anoka**
Contact—Position/Office:	**Amy Oehlers - Assistant City Manager**
Office Address:	**2015 1st Ave**
	Anoka, Minnesota - 55303-2245
	United States
Phone Number:	**763.576.2712**

NOTES

NOTES

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: $3,300 Individual, $6,600 Family Out-of-network: $7,000 Individual, $9,900 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $3,300 Individual, $6,600 Family Out-of-network: $27,000 Individual, $54,000 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/Achieve or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance Virtuwell: Not covered	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	0% coinsurance	50% coinsurance at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	0% coinsurance		
	Specialty drugs	$99,999 copay+9999900% 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-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	0% 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)	
stay	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	None
	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 day maximum
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	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.)

- Acupuncture
- 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.)

- 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, or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at:1-800-883-2177 or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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	**$3,300**
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	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,300**

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

The plan's overall deductible	**$3,300**
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	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,300**

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

The plan's overall deductible	**$3,300**
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: $3,300 Individual, $6,600 Family Out-of-network: $7,000 Individual, $9,900 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $3,300 Individual, $6,600 Family Out-of-network: $27,000 Individual, $54,000 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance Virtuwell: Not covered	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	0% coinsurance	50% coinsurance at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	0% coinsurance		
	Specialty drugs	$99,999 copay+9999900% 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-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	0% 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)	
stay	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	None
	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 day maximum
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	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.)

- Acupuncture
- 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.)

- 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, or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at:1-800-883-2177 or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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	**$3,300**
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	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,300**

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

The plan's overall deductible	**$3,300**
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	$3,300
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,300**

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

The plan's overall deductible	**$3,300**
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: $3,300 Individual, $6,600 Family Out-of-network: $7,000 Individual, $9,900 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,950 Individual, $11,900 Family Out-of-network: $27,000 Individual, $54,000 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance Virtuwell: 25% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance Virtuwell: Not covered	None
	Specialist visit	25% 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)	25% coinsurance	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: 25% coinsurance Non-formulary: 45% coinsurance	50% coinsurance at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	25% coinsurance		
	Non-formulary brand drugs	45% coinsurance		
	Specialty drugs	25% coinsurance	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	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	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	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)	
stay	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	25% coinsurance	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	None
	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	25% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	25% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	25% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	25% coinsurance	50% coinsurance	120 day maximum
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	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.)

- Acupuncture
- 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.)

- 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, or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at:1-800-883-2177 or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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	**$3,300**
Specialist coinsurance	**25%**
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	$3,300
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	**$3,300**
Specialist coinsurance	**25%**
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	$3,300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

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

The plan's overall deductible	**$3,300**
Specialist coinsurance	**25%**
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	$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: $3,300 Individual, $6,600 Family Out-of-network: $7,000 Individual, $9,900 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,950 Individual, $11,900 Family Out-of-network: $27,000 Individual, $54,000 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/Achieve or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 25% coinsurance Convenience Care: 25% coinsurance Virtuwell: 25% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance Virtuwell: Not covered	None
	Specialist visit	25% 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)	25% coinsurance	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: 25% coinsurance Non-formulary: 45% coinsurance	50% coinsurance at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	25% coinsurance		
	Non-formulary brand drugs	45% coinsurance		
	Specialty drugs	25% coinsurance	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	50% coinsurance	None
	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	25% coinsurance	25% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	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)	
stay	Physician/surgeon fees	25% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	25% coinsurance	50% coinsurance	None
	Inpatient services	25% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	None
	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	25% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	25% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	25% coinsurance	50% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	25% coinsurance	50% coinsurance	120 day maximum
	Durable medical equipment	25% coinsurance	50% coinsurance	None
	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.)

- Acupuncture
- 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.)

- 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, or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at:1-800-883-2177 or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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	**$3,300**
Specialist coinsurance	**25%**
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	$3,300
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,060**

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

The plan's overall deductible	**$3,300**
Specialist coinsurance	**25%**
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	$3,300
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,820**

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

The plan's overall deductible	**$3,300**
Specialist coinsurance	**25%**
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	$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: $5,000 Individual, $10,000 Family Out-of-network: $10,000 Individual, $20,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,000 Individual, $10,000 Family Out-of-network: $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, 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.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Office Visit: 40% coinsurance Convenience Care: 40% coinsurance Virtuwell: Not covered	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	0% coinsurance	40% coinsurance at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	0% coinsurance		
	Specialty drugs	$99,999 copay+9999900% coinsurance	40% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	0% coinsurance	40% 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)	
stay	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	40% coinsurance	120 day maximum
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	0% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% 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.)

- Acupuncture
- 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.)

- 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, or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at:1-800-883-2177 or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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	**$5,000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,000**

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

The plan's overall deductible	**$5,000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,000**

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

The plan's overall deductible	**$5,000**
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: $5,000 Individual, $10,000 Family Out-of-network: $10,000 Individual, $20,000 Family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Services marked with * and benefits with no charge under What You Will Pay are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network: $5,000 Individual, $10,000 Family Out-of-network: $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, 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/Achieve or call 1-800-883-2177 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance Virtuwell: 0% coinsurance	Office Visit: 40% coinsurance Convenience Care: 40% coinsurance Virtuwell: Not covered	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	0% coinsurance	40% coinsurance at retail, mail not covered	31 day supply retail / 93 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	0% coinsurance		
	Specialty drugs	$99,999 copay+9999900% coinsurance	40% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
If you have a hospital	Facility fee (e.g., hospital room)	0% coinsurance	40% 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)	
stay	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Habilitation services	0% coinsurance	40% coinsurance	Out-of-network: 20 visit limit/year
	Skilled nursing care	0% coinsurance	40% coinsurance	120 day maximum
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	0% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% 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.)

- Acupuncture
- 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.)

- 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, or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:Your plan at:1-800-883-2177 or the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-539-1600 / 1-800-657-3602 for the state insurance department.

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	**$5,000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$5,000**

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

The plan's overall deductible	**$5,000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$5,000**

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

The plan's overall deductible	**$5,000**
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**