

# PEIP Advantage HSA Family Plan Cost Level 4

## HealthPartners

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: Beginning on or after 01/01/2027  
Coverage for: Individual/Family | Plan Type: PPO



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit [www.healthpartners.com](http://www.healthpartners.com) or call 1-800-883-2177. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary> or call 1-800-883-2177 to request a copy.

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

| Important Questions                                                          | Answers                                                                                                                                                                              | Why this Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
|------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                             | \$6,750 individual / \$8,500 family medical and drug <a href="#">in-network</a>                                                                                                      | Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay.<br>This <a href="#">plan</a> has an embedded <a href="#">deductible</a> . If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .                                                          |
| Are there services covered before you meet your <a href="#">deductible</a> ? | Yes. Well child care, prenatal care and <a href="#">in-network preventive care</a> services are covered before you meet your <a href="#">deductible</a> .                            | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost-sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits">https://www.healthcare.gov/coverage/preventive-care-benefits</a> . |
| Are there other <a href="#">deductibles</a> for specific services?           | No                                                                                                                                                                                   | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| What is the <a href="#">out-of-pocket limit</a> for this plan?               | \$7,750 individual / \$10,500 family medical and drug <a href="#">in-network</a>                                                                                                     | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. This <a href="#">plan</a> has an embedded <a href="#">out-of-pocket limit</a> . If you have other family members on this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                     |
| What is not included in the <a href="#">out-of-pocket limit</a> ?            | <a href="#">Premiums</a> , <a href="#">balance-billing</a> charges (unless <a href="#">balanced billing</a> is prohibited), and health care this <a href="#">plan</a> doesn't cover. | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

|                                                                              |                                                                                                                                                         |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
|------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Will you pay less if you use an <a href="#">in-network provider</a> ?        | Yes. See <a href="http://www.healthpartners.com">www.healthpartners.com</a> or call 1-800-883-2177 for a list of <a href="#">in-network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">in-network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ? | Yes                                                                                                                                                     | This <a href="#">plan</a> will pay some or all fo the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a>                                                                                                                                                                                                                                                                                                                                                                                                                                                          |



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

| Common Medical Event                                                                                                                                                                              | Services You May Need                                  | What you Will Pay                                                                                                                       |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                    |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                                                                                                                                                   |                                                        | In-Network Provider<br>(You will pay the least)                                                                                         | Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                           |
| If you visit a health care <a href="#">provider's</a> office or clinic                                                                                                                            | Primary care visit to treat an injury or illness       | \$130 <a href="#">copay</a> /office visit                                                                                               | Not covered                                     | None                                                                                                                                                                                      |
|                                                                                                                                                                                                   | <a href="#">Specialist</a> visit                       | \$130 <a href="#">copay</a> /office visit                                                                                               | Not covered                                     | None                                                                                                                                                                                      |
|                                                                                                                                                                                                   | <a href="#">Preventive care/screening/immunization</a> | No charge                                                                                                                               | Not covered                                     | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for. |
| If you have a test                                                                                                                                                                                | <a href="#">Diagnostic test</a> (x-ray, blood work)    | 50% <a href="#">coinsurance</a>                                                                                                         | Not covered                                     | May require prior authorization.                                                                                                                                                          |
|                                                                                                                                                                                                   | Imaging (CT/PET scans, MRIs)                           | 50% <a href="#">coinsurance</a>                                                                                                         | Not covered                                     |                                                                                                                                                                                           |
| If you need drugs to treat your illness or condition.<br>More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.caremark.com">www.caremark.com</a> | Preferred generic drugs                                | \$30.00 <a href="#">copay</a> /retail<br>\$60.00 <a href="#">copay</a> /mail service<br>\$60.00 <a href="#">copay</a> /90dayRx retail   | Not covered                                     | For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.<br>May require prior authorization.                       |
|                                                                                                                                                                                                   | Preferred brand drugs                                  | \$50.00 <a href="#">copay</a> /retail<br>\$100.00 <a href="#">copay</a> /mail service<br>\$100.00 <a href="#">copay</a> /90dayRx retail | Not covered                                     |                                                                                                                                                                                           |
|                                                                                                                                                                                                   | Non-preferred drugs                                    | \$75.00 <a href="#">copay</a> /retail<br>\$150.00 <a href="#">copay</a> /mail service<br>\$150.00 <a href="#">copay</a> /90dayRx retail | Not covered                                     |                                                                                                                                                                                           |

| Common Medical Event                                                    | Services You May Need                                      | What you Will Pay                                                  |                                                 | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                  |
|-------------------------------------------------------------------------|------------------------------------------------------------|--------------------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                         |                                                            | In-Network Provider<br>(You will pay the least)                    | Out-of-Network Provider (You will pay the most) |                                                                                                                                                                                                                                                                         |
|                                                                         | <a href="#">Specialty drugs</a>                            | Refer to applicable prescription drug <a href="#">cost sharing</a> | Not covered                                     | For additional information on your prescription drug benefits, please refer to your prescription drug Pharmacy Benefit Manager.                                                                                                                                         |
| If you have outpatient surgery                                          | Facility fee (e.g., ambulatory surgery center)             | 50% <a href="#">coinsurance</a>                                    | Not covered                                     | May require prior authorization.                                                                                                                                                                                                                                        |
|                                                                         | Physician/surgeon fees                                     | No charge                                                          | Not covered                                     |                                                                                                                                                                                                                                                                         |
| If you need immediate medical attention                                 | <a href="#">Emergency room care</a>                        | \$600 <a href="#">copay</a> /visit                                 | \$600 <a href="#">copay</a> /visit              | None                                                                                                                                                                                                                                                                    |
|                                                                         | <a href="#">Emergency medical transportation</a>           | 50% <a href="#">coinsurance</a>                                    | 50% <a href="#">coinsurance</a>                 |                                                                                                                                                                                                                                                                         |
|                                                                         | <a href="#">Urgent care</a>                                | \$130 <a href="#">copay</a> /visit                                 | \$130 <a href="#">copay</a> /visit              | Out-of-network services applies to in-network deductible and out-of-pocket limit.                                                                                                                                                                                       |
| If you have a hospital stay                                             | Facility fee (e.g., hospital room)                         | 50% <a href="#">coinsurance</a>                                    | Not covered                                     | None                                                                                                                                                                                                                                                                    |
|                                                                         | Physician/surgeon fee                                      | No charge                                                          | Not covered                                     | None                                                                                                                                                                                                                                                                    |
| If you need mental health, behavioral health, or substance use services | Outpatient services                                        | \$100 <a href="#">copay</a> /visit                                 | Not covered                                     | Services for marriage/couples counseling are not covered. May require prior authorization.                                                                                                                                                                              |
|                                                                         | Inpatient services including adult mental health treatment | 50% <a href="#">coinsurance</a>                                    | Not covered                                     |                                                                                                                                                                                                                                                                         |
| If you are pregnant                                                     | Office visits                                              | Prenatal care: No charge<br>Postnatal care: No charge              | Not covered                                     | <a href="#">Cost-sharing</a> does not apply for <a href="#">preventive services</a> . Depending on the type of services, other <a href="#">cost-sharing</a> may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., ultrasound). |
|                                                                         | Childbirth/delivery professional services                  | No charge                                                          | Not covered                                     |                                                                                                                                                                                                                                                                         |
|                                                                         | Childbirth/delivery facility services                      | 50% <a href="#">coinsurance</a>                                    | Not covered                                     |                                                                                                                                                                                                                                                                         |
| If you need help recovering or have other special health needs          | <a href="#">Home health care</a>                           | 50% <a href="#">coinsurance</a>                                    | Not covered                                     | May require prior authorization.                                                                                                                                                                                                                                        |

| Common Medical Event                   | Services You May Need                     | What you Will Pay                                                                          |                                                 | Limitations, Exceptions, & Other Important Information                                                                                  |
|----------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------|
|                                        |                                           | In-Network Provider (You will pay the least)                                               | Out-of-Network Provider (You will pay the most) |                                                                                                                                         |
|                                        | <a href="#">Rehabilitation services</a>   | \$130 <a href="#">copay</a> for occupational therapy, physical therapy, and speech therapy | Not covered                                     | May require prior authorization.                                                                                                        |
|                                        | <a href="#">Habilitation services</a>     | \$130 <a href="#">copay</a> for occupational therapy, physical therapy, and speech therapy | Not covered                                     |                                                                                                                                         |
|                                        | <a href="#">Skilled nursing care</a>      | No charge after deductible                                                                 | Not covered                                     | 180-day maximum applies for all networks. 2 per hospice episode maximum per lifetime for all networks. May require prior authorization. |
|                                        | <a href="#">Durable medical equipment</a> | 50% <a href="#">coinsurance</a>                                                            | Not covered                                     | May require prior authorization.                                                                                                        |
|                                        | <a href="#">Hospice service</a>           | No charge after deductible                                                                 | Not covered                                     | None                                                                                                                                    |
|                                        | Children's eye exam                       | No charge                                                                                  | Not covered                                     | None                                                                                                                                    |
| If your child needs dental or eye care | Children's glasses                        | Not covered                                                                                | Not covered                                     | No coverage for these services                                                                                                          |
|                                        | Children's dental check-up                | Not covered                                                                                | Not covered                                     | No coverage for these services                                                                                                          |

#### Excluded Services & Other Covered Services:

| Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .) |                                                                                                                              |                                                                                                                                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Cosmetic surgery</li> <li>Dental care (Adult) (and children)</li> </ul>                                                                                    | <ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> </ul> | <ul style="list-style-type: none"> <li>Private duty nursing</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul> |
| Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)                                                      |                                                                                                                              |                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> </ul>                                                                                                          | <ul style="list-style-type: none"> <li>Chiropractic care</li> <li>Hearing aids</li> </ul>                                    | <ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Routine eye care (Adult)</li> </ul>                       |

**Your Rights to Continue Coverage** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Your plan at: 1-800-883-2177 or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also

provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Your plan at: 1-800-883-2177.

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

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-883-2177.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-883-2177.

**Notice of Nondiscrimination Practices**

Our Responsibilities: We follow Federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability or sex. We do not exclude people or treat them differently because of their race, color, national origin, age, disability or sex, including gender identity.

- We help people with disabilities to communicate with us. This help is free. It includes:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio and accessible electronic formats
- We provide services for people who do not speak English or who are not comfortable speaking English. These services are free. They include:
  - Qualified interpreters
  - Information written in other languages

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

If you have questions about our non-discrimination policy: Contact the Civil Rights Coordinator at 1-844-363-8732 or [integrityandcompliance@healthpartners.com](mailto:integrityandcompliance@healthpartners.com).

To File a Grievance: If you believe that we have not provided these services or have discriminated against you because of your race, color, national origin, age, disability or sex, you can file a grievance by contacting the Civil Rights Coordinator at 1-844-363-8732, [integrityandcompliance@healthpartners.com](mailto:integrityandcompliance@healthpartners.com) or Civil Rights Coordinator, Office of Integrity and Compliance, MS 21103K, 8170 33rd Ave. S., Bloomington, MN 55425.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services Room 509F, HHH Building 200 Independence Avenue SW, Washington, DC 20201

1-800-368-1019, 800-537-7697 (TDD)

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayment](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network prenatal care and a hospital delivery)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,750 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$130   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

**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*)

|                           |                 |
|---------------------------|-----------------|
| <b>Total Example Cost</b> | <b>\$12,700</b> |
|---------------------------|-----------------|

**In this example, Peg would pay:**

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$6,750 |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$500   |

#### **What isn't covered**

|                      |      |
|----------------------|------|
| Limits or exclusions | \$60 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Peg would pay is</b> | <b>\$7,310</b> |
|-----------------------------------|----------------|

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,750 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$130   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

**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*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$5,600</b> |
|---------------------------|----------------|

**In this example, Joe would pay:**

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$1,900 |
| <a href="#">Copayments</a>  | \$200   |
| <a href="#">Coinsurance</a> | \$0     |

#### **What isn't covered**

|                      |      |
|----------------------|------|
| Limits or exclusions | \$20 |
|----------------------|------|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Joe would pay is</b> | <b>\$2,120</b> |
|-----------------------------------|----------------|

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|                                                                 |         |
|-----------------------------------------------------------------|---------|
| ■ The <a href="#">plan's</a> overall <a href="#">deductible</a> | \$6,750 |
| ■ <a href="#">Specialist</a> <a href="#">copayment</a>          | \$130   |
| ■ Hospital (facility) <a href="#">coinsurance</a>               | 50%     |
| ■ Other <a href="#">coinsurance</a>                             | 50%     |

**This EXAMPLE event includes services like:**

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

|                           |                |
|---------------------------|----------------|
| <b>Total Example Cost</b> | <b>\$2,800</b> |
|---------------------------|----------------|

**In this example, Mia would pay:**

| <i>Cost Sharing</i>         |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$2,400 |
| <a href="#">Copayments</a>  | \$10    |
| <a href="#">Coinsurance</a> | \$0     |

#### **What isn't covered**

|                      |     |
|----------------------|-----|
| Limits or exclusions | \$0 |
|----------------------|-----|

|                                   |                |
|-----------------------------------|----------------|
| <b>The total Mia would pay is</b> | <b>\$2,410</b> |
|-----------------------------------|----------------|

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.