# Ameriprise Financial, Inc.
# Basic PPO Plan

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and this 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 Member Services at 1-877-835-9846. 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.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call Member Services at 1-877-835-9846 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Network: $600 Individual / $1,800 Family<br><br>Out-of-Network: $1,800 Individual / $5,400 Family. Per calendar year. | 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. Preventive care. | This plan covers some items and services even if you haven't yet met the deductible. 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, there are no other deductibles. | You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services. |
| **What is the out-of-pocket limit for this plan?** | Network: $3,500 Individual / $9,200 Family<br>Out-of-Network: $10,500 Individual / $31,500 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?** | Premiums, balance-billing charges, health care this plan doesn't cover, prescription copays and coinsurance, penalties for failure to obtain prior | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |

**Questions: Call Member Services at 1-877-835-9846**. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/UG-Glossary-508-MM.pdf or call the number above to request a copy.

| | | |
|---|---|---|
| | authorization and medical copays. | |
| **Will you pay less if you use a network provider?** | Yes, this plan uses network providers. If you use a out-of-network provider, your cost may be more. For a list of network providers, see **www.myuhc.com** or call the Member Services number at 1-877-835-9846. | 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 receive 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 | 20% co-ins | 40% co-ins | Virtual visits through Teladoc paid at 100%. No virtual visit coverage for out-of-network providers. If you receive services in addition to an office visit, additional copays, deductibles, or co-ins may apply. |
| | Specialist visit | 20% co-ins | 40% co-ins | ----------None---------- |
| | Preventive care/screening/ immunization | No Charge | 40% co-ins | You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive, and then check what the plan will pay for. Services are covered at 100% for in-network only. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% co-ins | 40% co-ins | Prior Authorization required for sleep studies. |
| | Imaging (CT/PET scans, MRIs) | 20% co-ins | 40% co-ins | Prior Authorization required for out-of-network |

| 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) | |
| | | **Retail Pharmacy (up to 30-day supply)** | **Mail Order Pharmacy/Walgreens (up to 90-day supply)** **90-day supply at Walgreens available only for non-specialty medications** | No out-of-network mail-order benefit is available. All mail-order prescriptions must be filled through the Express Scripts pharmacy. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.express-scripts.com | Tier 1 – Your Lowest-Cost Option (Generic) | 10% co-ins ($15minimum/ $35 maximum) | 10% co-ins ($35minimum/ $60 maximum) | You are allowed to fill a maintenance prescription (i.e., a drug that you take on a regular basis, such as for high blood pressure, etc.) at a retail pharmacy three times. Upon the fourth refill, you will be asked to pay double the retail co-insurance amount. |
| | Tier 2 – Your Midrange-Cost Option (Preferred Brand) | 25% co-ins ($35minimum/$75 maximum) | 25% co-ins ($60 minimum/$150 maximum) | You are allowed to fill a maintenance prescription (i.e., a drug that you take on a regular basis, such as for high blood pressure, etc.) at a retail pharmacy three times. Upon the fourth refill, you will be asked to pay double the retail co-insurance amount. |
| | Tier 3 – Your Highest-Cost Option (Non-Preferred Brands) | 45% co-ins ($60 minimum/$125 maximum) | 45% co-ins ($150 minimum/$250 maximum) | You are allowed to fill a maintenance prescription (i.e., a drug that you take on a regular basis, such as for high blood pressure, etc.) at a retail pharmacy three times. Upon the fourth refill, you will be asked to pay double the retail co-insurance amount. |
| | Tier 4 – Additional High-Cost Options (Specialty) | Not covered | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network |
| | Physician/surgeon fees | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network |
| **If you need immediate medical attention** | Emergency room care | 20% co-ins | 20% co-ins | ----------None---------- |
| | Emergency medical transportation | 20% co-ins | 40% co-ins | ----------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) | |
| | Urgent care | 20% co-ins | 40% co-ins | ----------None---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network |
| | Physician/surgeon fees | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network for certain treatments, partial hospitalization/intensive outpatient treatment and Intensive Behavioral Analysis (ABA). . Virtual behavioral health visits though Talkspace and Teladoc paid at 100%. Employee Assistance Program is limited to 6 visits per issue per calendar year. |
| | Inpatient services | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network inpatient facility |
| **If you are pregnant** | Office visits | 20% co-ins | 40% co-ins | Cost sharing does not apply for preventive services. Depending on the type of service, a copayment, coinsurance or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (e.g., an ultrasound). Prior Authorization required Out-of-Network Inpatient stays that exceed normal 48 hours for vaginal delivery or 96 hours for cesarean. |
| | Childbirth/delivery professional services | 20% co-ins | 40% co-ins | |
| | Childbirth/delivery facility services | 20% co-ins | 40% co-ins | |
| **If you need help recovering or have other special health needs** | Home health care | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network |
| | Rehabilitation services | 20% co-ins | 40% co-ins | Pulmonary and Cardiac Rehabilitation therapy is unlimited. Physical Therapy, Occupational Therapy, and Speech Therapy limited to 90 visits per calendar year per service type. |
| | Habilitation services | Not covered | Not covered | Habilitation Services are not covered. |

| 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) | |
| | Skilled nursing care | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network |
| | Durable medical equipment | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network for DME over $1,000 |
| | Hospice services | 20% co-ins | 40% co-ins | Prior Authorization required Out-of-Network before admission for an Inpatient Stay in a hospice facility |
| **If your child needs dental or eye care** | Children's eye exam | 20% co-ins | 40% co-ins | One per year |
| | Children's glasses | Not covered | Not covered | Children's glasses are not covered. |
| | Children's dental check-up | Not covered | Not covered | Children's dental check-ups are not covered. |

**Excluded Services & Other Covered Services:**

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Cosmetic surgery
- Dental care (Adult/Child)
- Glasses
- Habilitation services
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture – 20 visits per calendar year
- Bariatric surgery (see fact sheet)
- Infertility treatment (see Fact Sheet) - $20,000 lifetime maximum
- Hearing aids – 1 pair per 36 months
- Routine eye care (Adult) may be covered with limitations

**Your Rights to Continue Coverage:** For more information on your rights to continue coverage, you should review the Medical Plan Summary Plan Description on *Inside*. There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or http://www.dol.gov/ebsa/healthreform. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

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

provide complete information on how 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 or visit the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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

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

**Does this plan meet the 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 1-877-835-9846.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-835-9846.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-877-835-9846.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-877-835-9846.

*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 | $600 |
| Specialist *[cost sharing]* | $0 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit *(anesthesia)*

| | |
|---|---|
| **Total Example Cost** | **$12,700** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $600 |
| Copayments | $0 |
| Coinsurance | $2,400 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist *[cost sharing]* | $0 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| | |
|---|---|
| **Total Example Cost** | **$5,600** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $600 |
| Copayments | $0 |
| Coinsurance | $600 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,220** |

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

| | |
|---|---|
| The plan's overall deductible | $600 |
| Specialist *[cost sharing]* | $0 |
| Hospital (facility) *[cost sharing]* | 20% |
| Other *[cost sharing]* | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| | |
|---|---|
| **Total Example Cost** | **$2,800** |

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

| *Cost Sharing* | |
|---|---|
| Deductibles | $600 |
| Copayments | $0 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,000** |

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