

Ameriprise Financial, Inc. PPO with HSA 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 <u>deductible</u>?	Network: \$1,650 Individual / \$3,300 Family Out-of-Network: \$4,800 Individual / \$9,600 Family. Per calendar year.	Generally, you must pay all of the costs for prescriptions and from providers up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , you must meet the family <u>deductible</u> before the <u>plan</u> pays.
Are there services covered before you meet your <u>deductible</u>?	Yes. <u>Preventive care</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without cost-sharing and before you meet your <u>deductible</u> . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other <u>deductibles</u> for specific services?	No, there are no other <u>deductibles</u> .	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	Network: \$4,000 Individual / \$8,000 Family Out-of-Network: \$12,000 Individual / \$24,000 Family	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. Once a person covered under a family plan reaches the embedded individual <u>out-of-pocket limit</u> of \$6,850, all covered expenses for that person must be reimbursed at 100% even if the family <u>out-of-pocket</u> maximum has not been met.
What is not included in the <u>out-of-pocket limit</u>?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties for failure to obtain prior	Even though you pay these expenses, they don't count toward the <u>out-of-</u>

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	authorization and medical <u>copays</u> .	<u>pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes, this <u>plan</u> uses <u>network providers</u> . If you use a <u>out-of-network provider</u> your cost may be more. For a list of <u>network providers</u> , see www.myuhc.com or call the Member Services number at 1-877-835-9846.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's</u> network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you receive services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .

 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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% co-ins	40% co-ins	Virtual visits through Teladoc are payable at 100% after <u>network</u> deductible is satisfied. . No virtual visit coverage for <u>out-of-network</u> . If you receive services in addition to an office visit, additional copays, deductibles, or co-ins may apply.
	<u>Specialist</u> visit	20% co-ins	40% co-ins	-----None-----
	<u>Preventive care/screening/immunization</u>	No charge	40% co-ins	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive, and check to see what the <u>plan</u> will pay for. Services are covered at 100% for in-network only.
If you have a test	<u>Diagnostic test</u> (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 sleep studies.

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		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 <u>co-insurance</u> 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 <u>co-insurance</u> 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 <u>co-insurance</u> amount.
	Tier 4 – Additional High-Cost Options (<u>Specialty</u>)	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	<u>Emergency room care</u>	20% co-ins	2% co-ins	-----None-----
	<u>Emergency medical transportation</u>	20% co-ins	40% co-ins	-----None-----
	<u>Urgent care</u>	20% co-ins	40% co-ins	-----None-----

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you 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 for 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). . Cognitive Behavioral Therapy provided by AbleTo is covered at 100% no cost share for the initial consultation; ongoing therapeutic treatments are payable at 100% after In-Network deductible is satisfied. Virtual behavioral health visits through Talkspace and Teladoc are payable at 100% after in-network deductible is satisfied. . Employee Assistance Program is limited to 6 visits per issue per calendar year.
	Inpatient services	20% co-ins	40% co-ins	Prior Authorization required for 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. (i.e., 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	<u>Home health care</u>	20% co-ins	40% co-ins	Prior Authorization required Out-of-Network
	<u>Rehabilitation services</u>	20% co-ins	40% co-ins	Pulmonary and Cardiac Rehabilitation therapy is unlimited. Physical Therapy, Occupational Therapy, and Speech Therapy limited to 90 visits

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				per calendar year per service type.
	<u>Habilitation services</u>	Not covered	Not covered	Habilitation Services are not covered.
	<u>Skilled nursing care</u>	20% co-ins	40% co-ins	Prior Authorization required for Out-of-Network
	<u>Durable medical equipment</u>	20% co-ins	40% co-ins	Prior Authorization required Out-of-Network for DME over \$1,000
	<u>Hospice services</u>	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.)

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| <ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult/Child) • Glasses | <ul style="list-style-type: none"> • Habilitation services • Long-term care • Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> • Routine foot care • Weight loss programs |
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Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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| <ul style="list-style-type: none"> • Acupuncture – 20 visits per calendar year • Bariatric surgery (see fact sheet) | <ul style="list-style-type: none"> • Infertility treatment (see Fact Sheet) - \$20,000 lifetime maximum • Hearing aids – 1 pair per 36 months | <ul style="list-style-type: none"> • Routine eye care (Adult) may be covered with limitations |
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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

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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 or 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, kwijigo 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 <u>plan's</u> overall <u>deductible</u>	\$1650
■ <u>Specialist</u> [<u>cost sharing</u>]	\$0
■ Hospital (facility) [<u>cost sharing</u>]	20%
■ Other [<u>cost sharing</u>]	20%

This **EXAMPLE** event includes services like:

Specialist office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	\$12,700
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$1,650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$2,200
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,850

Managing Joe's type 2 Diabetes

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1650
■ <u>Specialist</u> [<u>cost sharing</u>]	\$0
■ Hospital (facility) [<u>cost sharing</u>]	20%
■ Other [<u>cost sharing</u>]	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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$1650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$00
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,670

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$1650
■ <u>Specialist</u> [<u>cost sharing</u>]	\$0
■ Hospital (facility) [<u>cost sharing</u>]	20%
■ Other [<u>cost sharing</u>]	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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$1650
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,850