




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 1-877-838-4949 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 1-877-838-4949 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$8,150 Individual/\$16,300 Family Out-of-network: \$20,000 Individual/\$40,000 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. Coinsurance marked with * in Common Medical Events and copays and benefits with no charge are not subject to deductible	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-network medical/pharmacy: \$8,150 Individual/\$16,300 Family There is no out-of-network out-of-pocket limit.	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 healthpartners.com/atlasnetwork or call 1-877-838-4949 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (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	Primary Office Visit: \$30 <u>copay</u> for the first three visits and 0% <u>coinsurance</u> thereafter Convenience Care: \$15 <u>copay</u> for the first three visits and 0% <u>coinsurance</u> thereafter virtuwell: No charge for the first three visits and 0% <u>coinsurance</u> thereafter	Primary Office Visit: 50% <u>coinsurance</u> Convenience Care: 50% <u>coinsurance</u>	Each family member's first three Primary Care visits are a copay. Other services like lab, x-rays, MRI/CT scans are covered at deductible/coinsurance.
	<u>Specialist visit</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services you need are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Imaging</u> (CT/PET scans, MRIs)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at healthpartners.com/geneticsadvantagerx	Generic drugs	Formulary: 0% <u>coinsurance</u> Non-formulary: 0% <u>coinsurance</u>	Formulary: 50% <u>coinsurance</u> at retail, mail not covered Non-formulary: 50% <u>coinsurance</u> at retail, mail not covered	30 day supply retail / 90 day supply mail order
	Formulary brand drugs	0% <u>coinsurance</u>	50% <u>coinsurance</u> at retail, mail not covered	
	Non-formulary brand drugs	0% <u>coinsurance</u>	50% <u>coinsurance</u> at retail, mail not covered	
	<u>Specialty drugs</u>	0% <u>coinsurance</u>	Not covered	Specialty drugs are limited to drugs on the specialty drug list and must be obtained from a designated vendor.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>Network Provider</u> (You will pay the least)	<u>Out-of-Network Provider</u> (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Out-of-network services apply to the in-network deductible.
	<u>Emergency medical transportation</u>	0% <u>coinsurance</u>	0% <u>coinsurance</u>	Out-of-network services apply to the in-network deductible.
	<u>Urgent care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Inpatient services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Childbirth/delivery facility services	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	Not covered	Limited to 60 visits per calendar year
	<u>Rehabilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 20 visits each per calendar year
	<u>Habilitation services</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 20 visits each per calendar year
	<u>Skilled nursing care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	30 day maximum
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	<u>Hospice services</u>	0% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u>	None
	Children's glasses	0% <u>coinsurance</u>	Not covered	Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per year.
	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 | • Infertility treatment | • Routine eye care (Adult) |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Termination of pregnancy, except in cases of rape, incest, or danger to the life of the mother. |
| • Dental care (Adult)(and children) | • Private-duty nursing | • Weight loss programs |
| • Hearing aids(Adult) | | |

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

- Chiropractic care

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, or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. 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 Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. Additionally, a consumer assistance program can help you file your appeal. Contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 1-877-838-4949.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-877-838-4949.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-877-838-4949.

Navajo (Dine): Dinekehgo shika at'ohwol ninisingo, kwijigo holne' 1-877-838-4949.

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	\$8,150
■ <u>Specialist coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$8,150
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Peg would pay is	\$8,210

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$8,150
■ <u>Specialist coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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	\$7,300
---------------------------	----------------

In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$7,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$60
The total Joe would pay is	\$7,060

Mia's Simple Fracture

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

■ The plan's overall deductible	\$8,150
■ <u>Specialist coinsurance</u>	0%
■ <u>Hospital (facility) coinsurance</u>	0%
■ <u>Other coinsurance</u>	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	\$1,900
---------------------------	----------------

In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$1,900
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900