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 1-855-813-3888 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](http://www.healthcare.gov/sbc-glossary) or call 1-855-813-3888 to request a copy.

### Important Questions

<table>
<thead>
<tr>
<th></th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
</table>
| **What is the overall deductible?** | In-network: $3,000  
Individual/$9,000 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. coinsurance marked with * under What You Will Pay 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/](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: $6,400 Individual/$12,800 Family  
Out-of-network medical/pharmacy: $30,000 Individual/$60,000 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 [http://www.healthpartners.com/rob in/focused](http://www.healthpartners.com/rob in/focused) or call 1-855-813-3888 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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>Primary Office Visit: $30 copay Convenience Care: $15 copay virtuwell: No charge</td>
<td>Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$50 copay</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>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.</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>25% coinsurance for x-ray/No charge for lab</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>Formulary Low Cost: $5 copay at retail, $10 copay at mail Formulary High Cost: $25 copay at retail, $50 copay at mail Non-formulary: $150 copay at retail, $300 copay at mail</td>
<td>Formulary: 50% coinsurance at retail, mail not covered Non-formulary: 50% coinsurance at retail, mail not covered</td>
<td>31 day supply retail/ 93 day supply mail order</td>
</tr>
<tr>
<td></td>
<td>Formulary brand drugs</td>
<td>$60 copay at retail, $120 copay at mail</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-formulary brand drugs</td>
<td>$150 copay at retail, $300 copay at mail</td>
<td>50% coinsurance at retail, mail not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance*</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>Out-of-network services apply to the in-network deductible.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical</td>
<td>25% coinsurance</td>
<td>25% coinsurance</td>
<td>Out-of-network services apply to the in-</td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------</td>
<td>-------------------</td>
<td>------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Network Provider</td>
<td>Out-of-Network Provider</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(You will pay the least)</td>
<td>(You will pay the most)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>$50 copay</td>
<td>$50 copay</td>
<td></td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance use disorder services</td>
<td>Outpatient services</td>
<td>$50 copay</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>Depending on the type of services, a copayment, coinsurance, or deductible may apply.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$50 copay</td>
<td>50% coinsurance</td>
<td>60 visit limit in-network, 30 visit limit out-of-network</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$50 copay</td>
<td>50% coinsurance</td>
<td>20 visit limit in and out-of-network for physical, occupational and speech therapy</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$50 copay</td>
<td>50% coinsurance</td>
<td>20 visit limit in and out-of-network for physical, occupational and speech therapy</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>Limited to 30 day maximum in-network, 15 day maximum out-of-network</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>25% coinsurance</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>25% coinsurance</td>
<td>Not covered</td>
<td>Limit of one pair of eyeglasses or contact lenses per year.</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Acupuncture</td>
</tr>
<tr>
<td>- Bariatric surgery</td>
</tr>
<tr>
<td>- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery</td>
</tr>
<tr>
<td>- Dental care (Adult)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Chiropractic care</td>
</tr>
</tbody>
</table>

**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:**


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): Dine’ehgo shika at’ohwol ninisingo, kwiijigo holne’ 1-800-883-2177.

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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.

<table>
<thead>
<tr>
<th>Coverage Example</th>
<th>Cost Sharing</th>
<th>What isn’t covered</th>
</tr>
</thead>
</table>
| **Peg is Having a Baby**  
(9 months of in-network pre-natal care and a hospital delivery) |  
- The plan’s overall deductible: $3,000  
- Specialist copay: $50  
- Hospital (facility) coinsurance: 25%  
- Other coinsurance: 25% | Deductibles $3,000  
Copayments $20  
Coinsurance $2,000  
Limits or exclusions $60  
The total Peg would pay is $5,080 |
| **Managing Joe’s type 2 Diabetes**  
(a year of routine in-network care of a well-controlled condition) |  
- The plan’s overall deductible: $3,000  
- Specialist copay: $50  
- Hospital (facility) coinsurance: 25%  
- Other coinsurance: 25% | Deductibles $1,900  
Copayments $1,200  
Coinsurance $0  
Limits or exclusions $60  
The total Joe would pay is $3,160 |
| **Mia’s Simple Fracture**  
(in-network emergency room visit and follow up care) |  
- The plan’s overall deductible: $3,000  
- Specialist copay: $50  
- Hospital (facility) coinsurance: 25%  
- Other coinsurance: 25% | Deductibles $1,600  
Copayments $200  
Coinsurance $0  
Limits or exclusions $60  
The total Mia would pay is $1,800 |

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

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

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, Peg would pay:
- Deductibles $3,000  
- Copayments $20  
- Coinsurance $2,000  
- Limits or exclusions $60  
- The total Peg would pay is $5,080

In this example, Joe would pay:
- Deductibles $1,900  
- Copayments $1,200  
- Coinsurance $0  
- Limits or exclusions $60  
- The total Joe would pay is $3,160

In this example, Mia would pay:
- Deductibles $1,600  
- Copayments $200  
- Coinsurance $0  
- Limits or exclusions $60  
- The total Mia would pay is $1,800
Statement of Nondiscrimination for Health Plan Members

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.

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 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
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)

Español (Spanish)
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al
1-800-883-2177. (TTY: 711)

Hmoob (Hmong)

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Goi số 1-800-883-2177. (TTY: 711)

Français (French)
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-883-2177. (ATS: 711)

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-883-2177. (телетайп: 711)

Af Soomaali (Somali)
OGAYSII: Haddii aad ku hadasho afka soomaaliga, Waxaa kuu diyaar ah caawimaad xagga luqadda ah oo bilaash ah. Fadlan soo wac 1-800-883-2177. (TTY: 711)

Tagalog (Tagalog)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-883-2177. (TTY: 711)
<table>
<thead>
<tr>
<th>Language</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italian</td>
<td>ATTENZIONE: In caso la lingua parlatia sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-883-2177. (TTY: 711)</td>
</tr>
<tr>
<td>Japanese</td>
<td>注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-883-2177 (TTY: 711) まで、お電話にてご連絡ください。</td>
</tr>
<tr>
<td>Nepali</td>
<td>नेपाली. यद्यपि अन्य भाषाओं में सहायता उपलब्ध है, फोन होने का सूत्र 1-800-883-2177 (TTY: 711)</td>
</tr>
<tr>
<td>Norwegian</td>
<td>Norsk. MERK: Hvis du snakker norsk, er gratis språkkassistentsetjene tilgjengelige for deg. Ring 1-800-883-2177. (TTY: 711)</td>
</tr>
<tr>
<td>Kharia (Gujarati)</td>
<td>ગુજરાતી ભાષાએ સહાય શીખવે છે, જે તમારી સહાય લેવા માટે ઉપલ્બધ છે. ફોન સંખ્યા: 1-800-883-2177. (TTY: 711)</td>
</tr>
</tbody>
</table>
| Ukrainian             | Українська (Ukrainian). УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.  
                            Телефонуйте за номером 1-800-883-2177. (телетайп: 711) |