

 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 800-883-2177 or visit us at [www.healthpartners.com](http://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 800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
<b>What is the overall <a href="#">deductible</a>?</b>	In-network: \$6,500 Individual/ \$13,000 Family Out-of-network: \$10,000 Individual/ \$20,000 Family	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. 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 deductible expenses paid by all family members meets the overall family deductible.
<b>Are there services covered before you meet your <a href="#">deductible</a>?</b>	Yes, some preventive care services are covered before you meet your deductible.	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 preventive services 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> .
<b>Are there other <a href="#">deductibles</a> for specific services?</b>	There are no other specific <a href="#">deductibles</a> .	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a>?</b>	In-network medical/pharmacy: \$6,800 Individual/\$13,600 Family Out-of-network medical/pharmacy: \$30,000 Individual/\$60,000 Family	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in 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.

Important Questions	Answers	Why This Matters:
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premium</a> , balance-billed 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 a <a href="#">network provider</a> ?	Yes. See <a href="http://www.healthpartners.com/openaccess">www.healthpartners.com/openaccess</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 plan's <a href="#">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="#">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> ?	No	You can see the in-network <a href="#">specialist</a> you choose without a <a href="#">referral</a> .



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

31 day supply retail / 93 day supply mail order. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and 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 <a href="#">provider's</a> office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: 0% <a href="#">coinsurance</a> Convenience Care: 0% <a href="#">coinsurance</a> Virtuwell: 0% <a href="#">coinsurance</a>	Primary Office Visit: 50% <a href="#">coinsurance</a> Convenience Care: 50% <a href="#">coinsurance</a>	None
	<a href="#">Specialist</a> visit	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	50% <a href="#">coinsurance</a>	You may have to pay for services that aren't <a href="#">preventive</a> . Ask your <a href="#">provider</a> if the services needed are <a href="#">preventive</a> . 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)	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://healthpartners.com/genericsadvantagerx">healthpartners.com/genericsadvantagerx</a>	Generic drugs	<a href="#">Formulary</a> : 0% <a href="#">coinsurance</a> <a href="#">Non-formulary</a> : 20% <a href="#">coinsurance</a>	<a href="#">Formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered <a href="#">Non-formulary</a> : 50% <a href="#">coinsurance</a> at retail, mail not covered	31 day supply retail / 93 day supply mail order. Select Preventive Drugs: Generic: No charge; Brand: \$60 copay. Formulary insulin covered with no member cost-sharing after a \$25 benefit cap per prescription per month.
	Formulary brand drugs	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> at retail, mail not covered	
	Non-formulary brand drugs	20% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a> at retail, mail not covered	
	<a href="#">Specialty drugs</a>	0% <a href="#">coinsurance</a>	Not covered	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need immediate medical attention</b>	<a href="#">Emergency room care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Emergency medical transportation</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Out-of-network services apply to the in-network deductible.
	<a href="#">Urgent care</a>	0% <a href="#">coinsurance</a>	0% <a href="#">coinsurance</a>	Out-of-Network services apply to the in-network deductible.
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Physician/surgeon fees	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you need mental health, behavioral health, or substance abuse needs</b>	Outpatient services	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	
	Inpatient services	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
<b>If you are pregnant</b>	Office visits	No charge	50% <a href="#">coinsurance</a>	Depending on the type of services, a copayment, coinsurance, or deductible may apply.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, and Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Childbirth/delivery professional services	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	Childbirth/delivery facility services	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	60 visits per calendar year
	<a href="#">Rehabilitation services</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 20 visits each per calendar year
	<a href="#">Habilitation services</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Limited to 20 visits each per calendar year
	<a href="#">Skilled nursing care</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	30 days per confinement
	<a href="#">Durable medical equipment</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	0% <a href="#">coinsurance</a>	50% <a href="#">coinsurance</a>	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days .
If your child needs dental or eye care	Children's eye exam	No charge	50% <a href="#">coinsurance</a>	None
	Children's glasses	0% <a href="#">coinsurance</a>	Not covered	Limited to one pair of eyeglasses (lenses and frames) or one pair of contact lenses per calendar year.
	Children's dental check-up	No charge	50% <a href="#">coinsurance</a>	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 <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Acupuncture</li> <li>Bariatric surgery</li> <li>Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <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>Chiropractic care</li> <li>Dental care (Children)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing aids (Adult)</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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform) 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](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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform), 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.**

[Minimum Essential Coverage](#) generally includes [plan](#), [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): 打这电话 码1-800-883-2177.

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

—————*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](#) \$6,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles</a>	\$6,500
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$70
<b>The total Peg would pay is</b>	<b>\$6,570</b>

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

- The [plan's overall deductible](#) \$6,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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** \$5,600

In this example, Joe would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$1,900
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
<b>The total Joe would pay is</b>	<b>\$1,920</b>

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

- The [plan's overall deductible](#) \$6,500
- [Specialist coinsurance](#) 0%
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 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** \$2,800

In this example, Mia would pay:

<a href="#">Cost Sharing</a>	
<a href="#">Deductibles*</a>	\$2,800
<a href="#">Copayments</a>	\$0
<a href="#">Coinsurance</a>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$2,800</b>