

 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 855-813-3888 or visit us at www.healthpartners.com/robin. 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 855-813-3888 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| What is the overall deductible? | In-network: \$0 Individual/ \$0 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, some preventive care services are covered before you meet your 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? | There are no other specific deductibles . | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-network medical/pharmacy: \$6,200 Individual/\$12,400 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. |

| Important Questions | Answers | Why This Matters: |
|--|---|---|
| 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 www.healthpartners.com/robin/broad or call 1-800-883-2177 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, 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 provider's office or clinic | Primary care visit to treat an injury or illness | Primary Office Visit: \$30 copay /Per Visit, Deductible does not apply Convenience Care: \$15 copay /Per Visit, Deductible does not apply Virtuwell: No charge | Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance | None |
| | Specialist visit | \$60 copay /Per Visit, Deductible does not apply | 50% coinsurance | None |
| | Preventive care/screening/immunization | No charge | 50% coinsurance | You may have to pay for services that aren't preventive . Ask your provider if the services needed are preventive . Then check what your plan will pay for. |

| 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 have a test | Diagnostic test (x-ray, blood work) | No charge | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | \$200 copay /Per Claim, Deductible does not apply | 50% coinsurance | None |
| If you need drugs to treat your illness or condition More information about prescription drug coverage is available at healthpartners.com/genericsadvantagerx | Generic drugs | Formulary Low Cost: \$5 copay /Per Prescription, Deductible does not apply at retail, \$15 copay /per 93 day supply, Deductible does not apply at mail Formulary High Cost: \$25 copay /Per Prescription, Deductible does not apply at retail, \$75 copay /per 93 day supply, Deductible does not apply at mail Non-formulary : \$150 copay /Per Prescription, Deductible does not apply \$450 copay /per 93 day supply, Deductible does not apply at mail | Formulary : 50% coinsurance at retail, mail not covered Non-formulary : 50% coinsurance at retail, mail not covered | 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. |
| | Formulary brand drugs | \$60 copay /Per Prescription, Deductible does not apply at retail, \$180 copay /per 93 day | 50% coinsurance at retail, mail not covered | |

| 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) | |
| | | supply, Deductible does not apply at mail | | |
| | Non-formulary brand drugs | \$150 copay /Per Prescription, Deductible does not apply at retail, \$450 copay /per 93 day supply, Deductible does not apply at mail | 50% coinsurance at retail, mail not covered | |
| | Specialty drugs | \$500 copay , Deductible does not apply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | \$2,000 copay | 50% coinsurance | None |
| | Physician/surgeon fees | No charge | 50% coinsurance | None |
| If you need immediate medical attention | Emergency room care | \$500 copay /Per Visit, Deductible does not apply | \$500 copay /Per Visit, Deductible does not apply | Out-of-network services apply to the in-network deductible. |
| | Emergency medical transportation | \$500 copay /Per trip, Deductible does not apply | \$500 copay /Per trip, Deductible does not apply | Out-of-network services apply to the in-network deductible. |
| | Urgent care | \$100 copay /Per Visit, Deductible does not apply | \$100 copay /Per Visit, Deductible does not apply | Out-of-Network services apply to the in-network deductible. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | \$2,000 copay | 50% coinsurance | Facility copay per day for the first three days of admission |
| | Physician/surgeon fees | No charge | 50% coinsurance | None |
| If you need mental health, behavioral health, or substance abuse needs | Outpatient services | \$30 copay /Per Visit, Deductible does not apply | 50% coinsurance | |
| | Inpatient services | Not applicable | Not applicable | None |
| If you are pregnant | Office visits | No charge | 50% coinsurance | 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 | \$2,000 copay | 50% coinsurance | Facility copay per day for the first three days of admission |
| | Childbirth/delivery facility services | No charge | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | Primary: \$30 copay /Per Visit, Deductible does not apply Specialty: \$60 copay /Per Visit, Deductible does not apply | 50% coinsurance | 60 visits per calendar year |
| | Rehabilitation services | Primary: \$30 copay /Per Visit, Deductible does not apply Specialty: \$60 copay /Per Visit, Deductible does not apply | 50% coinsurance | Limited to 20 visits each per calendar year |
| | Habilitation services | Primary: \$30 copay /Per Visit, Deductible does not apply Specialty: \$60 copay /Per Visit, Deductible does not apply | 50% coinsurance | Limited to 20 visits each per calendar year |
| | Skilled nursing care | \$60 copay /Per Day, Deductible does not apply | Not applicable | 30 days per period of confinement |
| | Durable medical equipment | No charge | 50% coinsurance | 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) | |
| | Hospice services | 20% coinsurance , Deductible does not apply | 50% coinsurance | Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days per episode . |
| If your child needs dental or eye care | Children's eye exam | No charge | 50% coinsurance | None |
| | Children's glasses | \$60 copay , Deductible does not apply | 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% coinsurance | 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 .) | | |
|---|---|---|
| <ul style="list-style-type: none"> Acupuncture Bariatric surgery Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery | <ul style="list-style-type: none"> Infertility treatment Long-term care Non-emergency care when traveling outside the U.S. | <ul style="list-style-type: none"> Private-duty nursing 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.) | |
|--|--|
| <ul style="list-style-type: none"> Chiropractic care Dental care (Children) | <ul style="list-style-type: none"> Hearing aids (Adult) Routine eye care (Adult) |

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 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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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](#).

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](#) \$0
- [Specialist copay](#) \$60
- Hospital (facility) [copayment](#) \$60
- Other [copayment](#) \$60

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 | \$0 |
| Copayments | \$600 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$70 |
| The total Peg would pay is | \$670 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copay](#) \$60
- Hospital (facility) [copayment](#) \$60
- Other [copayment](#) \$60

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* | \$0 |
| Copayments | \$800 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$20 |
| The total Joe would pay is | \$820 |

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

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copay](#) \$60
- Hospital (facility) [copayment](#) \$60
- Other [copayment](#) \$60

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* | \$0 |
| Copayments | \$2,000 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$2,000 |