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 1-800-883-2177 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 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $1,500 Individual, $3,000 Family Out-of-network: $4,500 Individual, $9,000 Family Your employer HRA contribution helps cover the cost of the deductible.	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. Services marked with * and benefits with no charge in Common Medical Events 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: $2,000 Individual, $4,000 Family Out-of-network medical: $6,000 Individual, $12,000 Family Pharmacy: $5,000 Individual, $10,000 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Pharmacy copays, pharmacy coinsurance, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 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
		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	Office Visit: 20% coinsurance Convenience Care: 20% coinsurance virtuwell: 20% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge for immunizations, 50% coinsurance for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: $10 copay* at retail, No charge at mail Non-formulary: $30 copay* at retail, No charge at mail	50% coinsurance at retail, mail not covered	30 day supply retail / 90 day supply mail order
	Formulary brand drugs	$20 copay* at retail, No charge at mail		
	Non-formulary brand drugs	$30 copay* at retail, No charge at mail		
	Specialty drugs	$99,999 copay*	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	20% coinsurance	50% coinsurance	Out-of-network: 15 visit limit/year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	50% coinsurance	120 maximum days per confinement

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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, or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517 for the state insurance department 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. 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 for the state insurance department. 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 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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**	**$1,500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**20%**

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	$1,500
Copayments	$0
Coinsurance	$500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

■ **The plan's overall deductible**	**$1,500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**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	**$7,300**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$400
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,060**

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

■ **The plan's overall deductible**	**$1,500**
■ **Specialist coinsurance**	**20%**
■ **Hospital (facility) coinsurance**	**20%**
■ **Other coinsurance**	**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	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$90
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,590**

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.
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Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $2,000 Individual, $4,000 Family Out-of-network: $5,000 Individual, $10,000 Family Your employer HRA contribution helps cover the cost of the deductible.	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. Services marked with * and benefits with no charge in Common Medical Events 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: $4,000 Individual, $8,000 Family Out-of-network medical: $7,000 Individual, $14,000 Family Pharmacy: $3,150 Individual, $6,300 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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Pharmacy copays, pharmacy coinsurance, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See https://www.healthpartners.com/networks 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 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
		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	Office Visit: 20% coinsurance Convenience Care: 20% coinsurance virtuwell: 20% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	None
	Specialist visit	20% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge for immunizations, 50% coinsurance for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	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.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	50% coinsurance	None

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 need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	Formulary: $12 copay* at retail, No charge at mail Non-formulary: $50 copay* at retail, No charge at mail	50% coinsurance at retail, mail not covered	30 day supply retail / 90 day supply mail order
	Formulary brand drugs	$35 copay* at retail, No charge at mail		
	Non-formulary brand drugs	$50 copay* at retail, No charge at mail		
	Specialty drugs	$99,999 copay*	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance	None
	Emergency medical transportation	20% coinsurance	20% coinsurance	None
	Urgent care	20% coinsurance	50% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	50% coinsurance	None
	Physician/surgeon fees	20% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	20% coinsurance	50% coinsurance	None
	Inpatient services	20% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	20% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	20% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	20% coinsurance	50% coinsurance	Out-of-network: 15 visit limit/year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	20% coinsurance	50% coinsurance	120 maximum days per confinement

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)	
	Durable medical equipment	20% coinsurance	50% coinsurance	None
	Hospice services	20% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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, or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517 for the state insurance department 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. 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 for the state insurance department. 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 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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	$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	$2,000
Copayments	$40
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,900**

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

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	**$7,300**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$2,000
Copayments	$800
Coinsurance	$100
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$2,960**

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

■ The plan's overall deductible	$2,000
■ Specialist coinsurance	20%
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	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	**$1,900**

In this example, Mia would pay:

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

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 1-800-883-2177 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 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $3,000 Individual, $6,000 Family Out-of-network: $6,000 Individual, $12,000 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. Services marked with * and benefits with no charge in Common Medical Events 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: $3,000 Individual, $6,000 Family Out-of-network: $8,000 Individual, $16,000 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, the overall family out-of-pocket limit must be 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 https://www.healthpartners.com/networks 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 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
		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	Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Office Visit: 50% coinsurance Convenience Care: 50% coinsurance virtuwell: Not covered	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	No charge for immunizations, 50% coinsurance for well child, 50% coinsurance for preventive care, 50% coinsurance for other services	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.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/hp/pharmacy/druglist/preferredrx/index.html	Generic drugs	0% coinsurance	50% coinsurance at retail, mail not covered	30 day supply retail / 90 day supply mail order
	Formulary brand drugs	0% coinsurance		
	Non-formulary brand drugs	0% coinsurance		
	Specialty drugs	$99,999 copay	50% coinsurance at retail, mail not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	None
	Emergency medical transportation	0% coinsurance	0% coinsurance	None
	Urgent care	0% coinsurance	50% coinsurance	None

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)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	None
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	50% coinsurance	Out-of-network: 15 visit limit/year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	0% coinsurance	50% coinsurance	120 maximum days per confinement
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	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.)

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- 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.)

- Acupuncture
- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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, or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517 for the state insurance department 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. 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 for the state insurance department. 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 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
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): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo 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	$3,000
■ 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:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,060**

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 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	**$7,300**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$3,060**

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

■ The plan's overall deductible	$3,000
■ 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	**$1,900**

In this example, Mia would pay:

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

NAME: _____

Return to Wendy Stauty, Executive Bookkeeper
by June 4, 2018

SCHOOL DISTRICT OF MAPLE
HEALTH INSURANCE OPTIONS
HEALTH PARTNERS

OPTION CHOICE:_____

OPTION A Original Renewal

Effective July 1, 2018 — District Plan 80% Co-Insurance
Renewal Rates — HRA - VEBA

Plan	Monthly	Yearly	Deductible	District Paid HRA
Family Plan	$ 1,824.46	$ 21,893.52	$ 3,000.00	$ 1,500.00
Single Plan	$ 608.15	$ 7,297.80	$ 1,500.00	$ 750.00

HardCap or maximum amount paid for by the District

Plan	Amount	Months	Yearly Cost
Family	$ 1,465.51	12	$ 17,586.12
Single	$ 485.17	12	$ 5,822.04

Difference in July 1 Option A rate and amount paid by the Employee

	Family Plan	Months 12	Yearly Cost	Pay Dates 26	Cost per Pay Date
July 1, 2017	$ 1,824.46				
District Share	$ 1,465.51				
Employee Share	$ 358.95		$ 4,307.40		$ 165.67

	Single Plan	Months 12	Yearly Cost	Pay Dates 26	Cost per Pay Date
July 1, 2017	$ 608.15				
District Share	$ 485.17				
Employee Share	$ 122.98		$ 1,475.76		$ 56.76

OPTION B

Effective July 1, 2018 — District Plan 80% Co-Insurance
Renewal Rates — HRA - VEBA

Plan	Monthly	Yearly	Deductible	District Paid HRA
Family Plan	$ 1,682.06	$ 20,184.72	$ 4,000.00	$ 1,500.00
Single Plan	$ 560.68	$ 6,728.16	$ 2,000.00	$ 750.00

HardCap or maximum amount paid for by the District

Plan	Amount	Months	Yearly Cost
Family	$ 1,484.66	12	$ 17,815.92
Single	$ 491.55	12	$ 5,898.60

Difference in July 1 Option B rate and amount paid by the Employee

	Family Plan	Months 12	Yearly Cost	Pay Dates 26	Cost per Pay Date
July 1, 2016	$ 1,682.06				
District Share	$ 1,484.66				
Employee Share	$ 197.40		$ 2,368.80		$ 91.11

	Single Plan	Months 12	Yearly Cost	Pay Dates 26	Cost per Pay Date
July 1, 2016	$ 560.68				
District Share	$ 491.55				
Employee Share	$ 69.13		$ 829.56		$ 31.91

OPTION C

Effective July 1, 2018 — District Plan
Renewal Rates — HSA
Individual option, however cannot have an HRA Plan and HSA

Plan	Monthly	Yearly	Deductible	District Funded
Family Plan	$ 1,641.50	$ 19,698.00	$ 6,000.00	$ 1,500.00
Single Plan	$ 547.16	$ 6,565.92	$ 3,000.00	$ 750.00

No Rx
Preventive care = 100%; everything else toward deductible
Can have no other health insurance plan with an HSA

HardCap or maximum amount paid for by the District

Plan	Amount	Months	Yearly Cost
Family	$ 1,477.38	12	$ 17,728.56
Single	$ 489.12	12	$ 5,869.44

Difference in July 1 Option C rate and amount paid by the Employee

	Family Plan	Months 12	Yearly Cost	Pay Dates 26	Cost per Pay Date
July 1, 2016	$ 1,641.50				
District Share	$ 1,477.38				
Employee Share	$ 164.12		$ 1,969.44		$ 75.75

	Single Plan	Months 12	Yearly Cost	Pay Dates 26	Cost per Pay Date
July 1, 2016	$ 547.16				
District Share	$ 489.12				
Employee Share	$ 58.04		$ 696.48		$ 26.79

COMPLETE ONLY IF CHANGING OPTIONS (i.e., Option A to Option B)

5/15/2018