

 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.doi.gov/ehsa/pdf/SBCUniformGlossary.pdf 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: \$9,000 Individual/\$18,000 Family | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible. |
| Are there services covered before you meet your deductible? | Yes. Coinsurance marked with * in Common Medical Events and benefits with no charge are not subject to deductible | This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ . |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | In-network medical/pharmacy: \$3,250 Individual/\$6,500 Family Out-of-network medical/pharmacy: \$27,000 Individual/\$54,000 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 www.healthpartners.com/openacc 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 | Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance | Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance | None |
| | Specialist visit | 0% coinsurance | 50% coinsurance | None |
| | Preventive care/screening/immunization | No charge | No charge for immunizations/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 http://www.healthpartner.com/public/pharmacy/formularies/genericplus/ | Generic drugs | Formulary: 0% coinsurance Non-formulary: 20% coinsurance | 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. Select Preventive Drugs \$12 copay generic/\$45 brand, deductible does not apply. |
| | Formulary brand drugs | 0% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Non-formulary brand drugs | 20% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Specialty drugs | 0% coinsurance | 50% coinsurance at retail, mail not covered | |
| | Facility fee (e.g., ambulatory surgery center) | 0% coinsurance | 50% coinsurance | |
| If you have outpatient surgery | Physician/surgeon fees | 0% coinsurance | 50% coinsurance | None |
| | Emergency room care | 0% coinsurance | 0% coinsurance | Out-of-network services apply to the in-network deductible. |
| If you need immediate medical attention | Emergency medical | 0% coinsurance | 0% coinsurance | Out-of-network services apply to the in- |

| 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 | transportation | 0% coinsurance | 50% coinsurance | network deductible. |
| | Urgent care | 0% coinsurance | 50% coinsurance | None |
| | Facility fee (e.g., hospital room) Physician/surgeon fees | 0% coinsurance 0% coinsurance | 50% coinsurance 50% coinsurance | None 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 | Depending on the type of services, a copayment, coinsurance, or deductible may apply. |
| | Childbirth/delivery professional services | 0% coinsurance | 50% coinsurance | None |
| If you need help recovering or have other special health needs | Childbirth/delivery facility services | 0% coinsurance | 50% coinsurance | None |
| | Home health care | 0% coinsurance | 50% coinsurance | 120 visit limit |
| | Rehabilitation services | 0% coinsurance | 50% coinsurance | None |
| | Habilitation services | Not Covered | Not Covered | None |
| | Skilled nursing care | 0% coinsurance | 50% coinsurance | 120 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.)

- | | | |
|---|---|---|
| <ul style="list-style-type: none"> • Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult) | <ul style="list-style-type: none"> • Hearing aids • Infertility treatment • Long-term care | <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.)

- 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 Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.ccio.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 grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact Your plan at 1-800-883-2177 or the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517. Additionally, a consumer assistance program can help you file your appeal. Contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517.

Does this plan provide Minimum Essential Coverage? Yes.

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

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.

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): Dinekehgo shika at'ohwol ninisingo, kwijijigo 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$3,000 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| 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:

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