Renewal Information and Exhibits

Prepared For:

City of Berlin

Group ID: G000C6NV

Renewal Effective Date: October 1, 2026

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Mutual of Omaha - Confidential

Mutual of Omaha

Thank you for choosing Mutual of Omaha Insurance Company or one of its affiliates, as City of Berlin's benefits provider. It has been our pleasure to provide City of Berlin with group benefits and services that are unique to its needs. We are committed to providing unparalleled service that will meet the needs of our customers.

Each renewal period, we analyze current benefit and rate structures to determine the appropriate rates for continued group insurance protection for your valued employees. This process includes recalculation of the premium rates to reflect factors like:

- Plan features
- Demographics
- Experience
- Any adjustments to our underlying rate structure

Based on our review, please find below the renewal rates for City of Berlin's benefit plans. We appreciate your business and look forward to the continued opportunity to meet your group insurance needs.

As a producer for our company, we request that you provide the renewal rate information described in this letter to City of Berlin by June 1, 2026 in order to meet mandated renewal notice requirements.

Renewal Contact Information

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MUTUAL of OMAHA

CITY OF BERLIN

LIFE AND AD&D

Rate Guarantee Period - October 1, 2026 to October 1, 2028
Additional Value Added Services - Employee Assistance Program (EAP), Travel Assistance/Identity Theft Assistance

Life

Current Monthly Premium	Renewal Monthly Premium	Renewal Monthly Premium Change
$108.00	$108.00	$0.00

Class Description

All Eligible Employees
Employee Rate Basis - per $1,000

Lives	Volume	Current Rate	Renewal Rate
54	$540,000	$0.20	$0.20

AD&D

Current Monthly Premium	Renewal Monthly Premium	Renewal Monthly Premium Change
$21.60	$21.60	$0.00

Class Description

All Eligible Employees
Employee Rate Basis - per $1,000

Lives	Volume	Current Rate	Renewal Rate
54	$540,000	$0.04	$0.04

Mutual of Omaha

CITY OF BERLIN

VOLUNTARY ACCIDENT

Rate Guarantee Period - October 1, 2026 to October 1, 2028

Voluntary Accident

Current Monthly Premium	Renewal Monthly Premium	Renewal Monthly Premium Change
$288.28	$288.28	$0.00

Class Description

All Eligible Employees

Employee

Lives	Volume	Current Rate	Renewal Rate
16	N/A	$7.79	$7.79

Employee and Spouse

Lives	Volume	Current Rate	Renewal Rate
4	N/A	$11.58	$11.58

Employee and Children

Lives	Volume	Current Rate	Renewal Rate
2	N/A	$16.06	$16.06

Employee and Family

Lives	Volume	Current Rate	Renewal Rate
4	N/A	$21.30	$21.30

Mutual of Omaha
Accident – Child Sports Injury Booster Benefit

Why did Mutual of Omaha add a new benefit to the Accident contract?

We are continually looking for ways to improve the products and services we offer to ensure you and your employees are insured with modern, best-in-class provisions that lead the industry. With your renewal, you will receive an updated Accident contract that now includes a Child Sports Injury Booster benefit.

What is the advantage of Child Sports Injury Booster benefit?

- Supplemental benefit added to the accident certificate.
- Pays additional benefits if a covered child is injured while participating in an organized sporting activity (e.g., school or league athletics).
- Applies to accidental injuries such as fractures, dislocations, concussions, or sprains sustained during sporting activities.

Will this affect rates?

No. We are adding this benefit to the Accident product with no impact on rates.

Will other benefits or claims be affected by the Child Sports Injury Booster benefit?

There will be no change in how benefits are paid for accidents that occurred prior to the renewal date of the addition of this new benefit. The new benefit is effective as soon as the renewal contract becomes effective for your group.

2026 Health Insurance Renewal

Executive Summary

The City's HealthPartners medical plan is renewing with an 11.9% premium increase for the 2026–2027 plan year. To better manage this increase while preserving employee choice, the proposed renewal includes two key changes: transitioning to a 90% employer / 10% employee contribution strategy and adopting a base, buy-up, and buy-down funding approach.

Renewal Overview

HealthPartners' actuarial analysis, negotiation, and contribution strategy together shaped the City's 2026 health insurance renewal outcome.

Step 1 | Carrier's Initial Analysis

HealthPartners' actuarial analysis initially supported a renewal increase of **28%**, driven by a Medical Loss Ratio of **108.3%** (target score: 87%) and there are two ongoing high-cost claimants totaling approximately $77,000. Despite this claims experience, HealthPartners reduced the proposed increase to **14.9%** following initial renewal discussions.

28% → 14.9%

Initial Proposed → First Offer

108.3% MLR

vs. 87% Target MLR

Step 2 | Final Negotiation

Following an additional round of negotiations, HealthPartners agreed to further reduce the renewal from **14.9%** to **11.9%** while maintaining the City's current $3,500 HSA benefit design.

Negotiation Results

$3500 Deductible Plan
Initial Renewal (14.9%)
Final Renewal (11.9%)

Renewal Overview

Step 3 | Contribution Strategy

The recommendation also updates the City's contribution philosophy from 93%/7% to 90%/10%, allowing the City to offset a portion of the renewal while continuing to provide a highly competitive employer contribution.

Full Picture

Strategy	Annual Employer Cost	Difference
Current Plan (93/7)	$730,777	
Initial Renewal (14.9%, 93/7)	$839,663	+$108,886
Final Renewal (11.9%, 93/7)	$817,739	-$21,924 vs. initial renewal
Final Renewal (11.9%, 90/10)	**$791,361**	**-$48,302 vs. Initial renewal**
Net City Savings (90/10 vs. Current)	**$791,361 / year**	+$48,302

> *Together, carrier negotiations and the updated contribution strategy reduced the City's projected employer renewal cost by approximately $48,300 from the initial renewal, while preserving the current benefit design and maintaining a highly competitive employer contribution.*

Renewal Overview

Step 4 | Base, Buy-Up & Buy-Down Strategy

Rather than contributing equally toward every medical plan, the City will anchor its contribution to the HealthPartners Focused Network, creating a sustainable funding strategy while continuing to provide employees with three network choices.

Base Plan

HealthPartners Focused Network — The City's contribution is anchored here. Employees electing this plan pay their standard 10% share.

Buy-Up Option

HealthPartners Broad Network — Employees who prefer broader provider access may elect this plan and pay the additional premium difference through payroll deductions.

Buy-Down Option

HealthPartners Select Network — Employees seeking the lowest-cost option may elect this plan at a reduced employee contribution.

Renewal Overview

ⓘ **Step 4 | Base, Buy-Up & Buy-Down Strategy (continued)**

Estimated City Savings from Anchoring to Focused Network

Based on current Broad enrollment of 27 employees, if all remain on Broad, the City saves approximately $41,681/year. *This is before accounting for any employees who switch to Focused, which would increase savings further.*

Coverage Tier	Enrolled	Monthly Savings/EE	Annual Savings
Employee Only	10	$64.08	$7,690
Employee + Spouse	4	$121.81	$5,847
Employee + Children	2	$121.81	$2,923
Family	11	$191.07	$25,221
Total (27 Broad enrollees)	**27**	**—**	**$41,681/year**

Renewal Overview

Step 5 | Employee Choice in Action

	Base	Buy-Up	Buy-Down
Plan	Focused	Broad	Select
Best For	Most EE's	EE's wanting the largest provider network	EE's prioritizing the lowest payroll deduction
Employer Contribution	Based on this plan	Same ER contribution as Focused	Same ER contribution as Focused
Employee Pays	Standard 10% share	Standard 10% + premium difference	Less than the standard 10% share
Monthly Impact	—	+$62–$186/month	Saves $78–$233/month

Level-Funded Market Evaluation

As part of a comprehensive renewal process, Vizance explored all available funding strategies, including level-funded arrangements, to ensure the City had access to the full spectrum of cost-management options.

Level-funded plans can offer some savings for groups with favorable claims experience by combining fixed monthly costs with the potential for year-end refunds when utilization is lower than projected.

UHC

UnitedHealthcare issued a **Declination to Quote (DTQ)** for a level-funded arrangement. No alternative level-funded product was made available by UHC for this renewal cycle.

Anthem

Anthem was solicited for multiple level-funded proposal. **No quote was submitted**, leaving this option unavailable for comparison.

Network Health

Network Health was also approached multiple times for a level-funded proposal. **No quote was submitted**, further confirming the absence of competitive level-funded alternatives in the current market.

As a result of these outcomes, **there are no competitive level-funded alternatives available for consideration at this renewal**.

Renewal Timeline & Next Steps

As we move towards finalizing the City's health insurance offerings, the following timeline outlines the critical milestones for the upcoming renewal cycle.

Council Review and Plan Selection

Employee Open Enrollment Communications

Open Enrollment Period

New Plan Effective Date: October 1, 2026

Robin Networks

Available to ALL group sizes, in ANY combination.

	Broad	Focused	Select
Network Providers* *HSHS/Prevea and MAYO are out of network on all fully insured Robin Network options.	• Bellin & Bellin ACO • ThedaCare & TC ACO • Holy Family • Aurora • Ascension • SSM • Children's Hospital • CIGNA National Network ➢ 950K Providers/6300 Hospitals ➢ Froedtert/MCOW ➢ Marshfield ➢ UW Hospitals & Clinics	• Bellin & Bellin ACO • ThedaCare & TC ACO • Holy Family • Aurora • Children's Hospital • CIGNA National Network ➢ 950K Providers/6300 Hospitals ➢ Froedtert/MCOW ➢ Marshfield ➢ UW Hospitals & Clinics	• Bellin & Bellin ACO • ThedaCare & TC ACO • Holy Family • Children's Hospital Out of Area Care Covered in-network: - Urgent/Emergent - Chronic care when directed by Select provider - Out of Network care when directed by Select Prov
Relative Cost	$$$	$$ (About 8% lower than Broad)	$ (About 18-20% lower than Broad)
Web Links	Healthpartners.com/robin/broad	Healthpartners.com/robin/focused	Healthpartners.com/robin/select

City Of Berlin - 41301

Effective Date: October 1, 2026

WN763 HSA Broad NE WI E		NE WI Broad		*WN883*		EZ $3500-100% NE WI Broad
	Enrollment	*Current Rates*		*Renewal Rates*		
Single	10	$	697.13	$	780.09	
Single + Spouse	4	$	1,325.15	$	1,482.84	
Single + Child(ren)	2	$	1,325.15	$	1,482.84	
Family	10	$	2,078.75	$	2,326.12	
	Revenue:	$	35,710	$	39,959.16	11.90%

WN764 HSA Focused NE W		NE WI Focused		*WN884*		EZ $3500-100% NE WI Focused
	Enrollment	*Current Rates*		*Renewal Rates*		
Single	9	$	641.36	$	717.68	
Single + Spouse	3	$	1,219.14	$	1,364.22	
Single + Child(ren)	3	$	1,219.14	$	1,364.22	
Family	8	$	1,912.45	$	2,140.03	
	Revenue:	$	28,387	$	31,764.69	11.90%

	Current	Renewal
COMBINED REVENUE:	$64,096	$71,724
		11.90%

* Rates assume group can contribute up to the annual deductible toward the employee's HSA/HRA.
* Rates include $25 Per Contract Broker Commission.
* Refer to plan guides for determination of creditable coverage.
* Embedded EAP included with all EZ plans.

Broad-Buy Up

Total Plan Cost **$479,509.68**

Monthly Plan Cost		Monthly Employee Cost		Annual Employee Cost		Monthly Employer Cost		Monthly Employer Enrolled Cost	Annual Employer Cost		Annual Employer Enrolled Cost	Number of Employees
Single	$780.09	Single	$134.18	Single	$1,610.16	Single	$645.91	$6,459.10	Single	$7,750.92	$77,509.20	10
Single + SP	$1,482.84	Single + SP	$255.04	Single + SP	$3,060.48	Single + SP	$1,227.80	$4,911.20	Single + SP	$14,733.60	$58,934.40	4
Single + CH	$1,482.84	Single + CH	$255.04	Single + CH	$3,060.48	Single + CH	$1,227.80	$2,455.60	Single + CH	$14,733.60	$29,467.20	2
Family	$2,326.12	Family	$400.09	Family	$4,801.08	Family	$1,926.03	$19,260.30	Family	$23,112.36	$231,123.60	10
Total Paid					**$82,475.28**						**$397,034.40**	
with PD Adjustment												
with no take payout	$78.01											
	$148.28											
	$148.28											
	$232.61											

Focused-Base

Total Plan Cost **$381,176.16**

Monthly Plan Cost		Monthly Employee Cost		Annual Employee Cost		Monthly Employer Cost		Monthly Employer Enrolled Cost	Annual Employer Cost		Annual Employer Enrolled Cost	Number of Employees
Single	$717.68	Single	$71.77	Single	$861.24	Single	$645.91	$5,813.19	Single	$7,750.92	$69,758.28	9
Single + SP	$1,364.22	Single + SP	$136.42	Single + SP	$1,637.04	Single + SP	$1,227.80	$3,683.40	Single + SP	$14,733.60	$44,200.80	3
Single + CH	$1,364.22	Single + CH	$136.42	Single + CH	$1,637.04	Single + CH	$1,227.80	$3,683.40	Single + CH	$14,733.60	$44,200.80	3
Family	$2,140.03	Family	$214.00	Family	$2,568.00	Family	$1,926.03	$15,408.24	Family	$23,112.36	$184,898.88	8
Total Paid Annually					**$38,117.40**						**$343,058.76**	
with PD Adjustment												
with no take payout	$71.77											
	$136.42											
	$136.42											
	$214.00											

Select-Buy Down

Total Plan Cost **$732,941.40**

		Monthly Employee Cost		Annual Employee Cost		Monthly Employer Cost		Monthly Employer Enrolled Cost	Annual Employer Cost		Annual Employer Enrolled Cost	Number of Employees
Single	639.67	Single	$63.97	Single	$767.64	Single	$575.70	$10,938.30	Single	$6,908.40	$131,259.60	19
Single + SP	1215.93	Single + SP	$121.59	Single + SP	$1,459.08	Single + SP	$1,094.34	$7,660.38	Single + SP	$13,132.08	$91,924.56	7
Single + CH	1215.93	Single + CH	$121.59	Single + CH	$1,459.08	Single + CH	$1,094.34	$5,471.70	Single + CH	$13,132.08	$65,660.40	5
Family	1907.42	Family	$190.74	Family	$2,288.88	Family	$1,716.68	$30,900.24	Family	$20,600.16	$370,802.88	18
Total Paid Annually					**$73,293.96**						**$659,647.44**	
with PD Adjustment												
with no take payout	$63.97											
	$121.59											
	$121.59											
	$190.74											

Plan Type	Current	Renewal	Robin Broad	Robin Focused only	Robin Select
TOTAL	$760,859	$ 860,686	$893,831	$822,325	$ 732,941
Employer	$705,197	$ 740,092	$740,092	$740,093	$ 659,647
Employees	$55,662	$ 120,593	$153,738	$82,233	$ 73,294

Plan Type	Robin Broad (Current)	Robin Broad (2027)	Robin Focused (Current)	Robin Focused (2027)	Robin Select (2027)
Single	$52.28	$134.18	$48.10	$71.77	$63.97
Employee + Spouse	$99.34	$255.04	$91.44	$136.42	$121.59
Employee + Children	$99.39	$255.04	$91.44	$136.42	$121.59
Family	$155.91	$400.09	$143.43	$214.00	$190.74

Robin's Broad Network $3500/100% Plan with dental

Total Plan Cost $ 479,510

		Monthly Plan Cost		Annual Employee Cost		Annual Employer Cost	Number of Employees	Additional Employee Contributions Monthly	Additional Employee Contributions Annual
At 10% employee contribution	Single	$ 780.09	Single	$ 1,610.16	Single	$ 7,750.92	10	$ 81.90	$ 982.74
	+ Spouse	$ 1,482.84	+ Spouse	$ 3,060.48	+ Spouse	$ 14,733.58	4	$ 155.65	$ 1,867.84
	+ Children	$ 1,482.84	+ Children	$ 3,060.48	+ Children	$ 14,733.58	2	$ 155.65	$ 1,867.84
	Family	$ 2,326.12	Family	$ 4,801.08	Family	$ 23,112.32	10	$ 244.18	$ 2,930.20
TOTAL Paid Annually				$ 82,475.28		$ 397,033.88			
				$ 82,475.28		$ 397,033.88			
with no take payout		$ 134.18				**$ 413,833.88**	$ 16,800.00		
		$ 255.04							
		$ 400.09							

Plan Type	Current	Renewal
TOTAL	$760,859	$ 860,686
Employer	$705,197	$ 740,092
Employees	$55,662	$ 120,593

Plan Type	Robin Broad (Current)	Robin Broad (2027)
Single	$52.28	$134.18
Employee + Spouse	$99.34	$255.04
Employee + Children	$99.39	$255.04
Family	$155.91	$400.09

Robin's Focused Network $3500/100% Plan with dental

Total Plan Cost $ 381,176

		Monthly Plan Cost		Annual Employee Cost		Annual Employer Cost	Number of Employees	Additional Employee Contributions Monthly	Additional Employee Contributions Annual
At 10% employee contribution	Single	$ 717.68	Single	$ 861.22	Single	$ 7,750.94	9	$ 23.67	$ 284.00
	+ Spouse	$ 1,364.22	+ Spouse	$ 1,637.06	+ Spouse	$ 14,733.58	3	$ 44.98	$ 539.83
	+ Children	$ 1,364.22	+ Children	$ 1,637.06	+ Children	$ 14,733.58	3	$ 44.98	$ 539.83
	Family	$ 2,140.03	Family	$ 2,568.04	Family	$ 23,112.32	8	$ 70.57	$ 846.83
TOTAL Paid Annually				$ 38,117.62		$ 343,058.54			
				$ 38,117.62		$ 343,058.54			
with no take payout		$ 71.77				**$ 343,058.54**			
		$ 136.42							
		$ 214.00							

TOTAL for Focused and Broad $ 740,092.42
with no take payout $ 756,892.42

Robin's Select Network $3500/100% Plan with dental ALL EMPLOYEES TAKING

Total Plan Cost $ 732,941

		Monthly Plan Cost		Annual Employee Cost		Annual Employer Cost	Number of Employees	Additional Employee Contributions compared to Focus in 2026 Monthly	Additional Employee Contributions compared to Focus in 2026 Annual
At 10% employee contribution	Single	$ 639.67	Single	$ 767.60	Single	$ 6,908.44	19	$ 15.87	$ 190.38
	+ Spouse	$ 1,215.93	+ Spouse	$ 1,459.12	+ Spouse	$ 13,132.04	7	$ 30.15	$ 361.89
	+ Children	$ 1,215.93	+ Children	$ 1,459.12	+ Children	$ 13,132.04	5	$ 30.15	$ 361.89
	Family	$ 1,907.42	Family	$ 2,288.90	Family	$ 20,600.14	18	$ 47.31	$ 567.69
TOTAL Paid Annually				$ 73,294.14		$ 659,647.26			
				$ 73,294.14		$ 659,647.26			
with no take payout		$ 63.97				**$ 676,447.26**	$ 16,800.00		
		$ 121.59							
		$ 190.74							

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 or call 1-855-813-3888 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $3,500 Individual, $7,000 Family Out-of-network: $7,000 Individual, $14,000 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 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: $3,500 Individual, $7,000 Family Out-of-network medical/pharmacy: $14,000 Individual, $28,000 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/Broad 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.

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: No charge	Primary Office Visit: 40% coinsurance Convenience Care: 40% coinsurance	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% 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	Formulary: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 40% coinsurance at retail, mail not covered Non-preferred: 40% coinsurance at retail, mail not covered	Days Supply: 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	0% coinsurance	40% coinsurance at retail, mail not covered	
	Non-preferred brand drugs	0% coinsurance	40% coinsurance at retail, mail not covered	
	Specialty drugs	0% coinsurance	40% coinsurance at retail, mail not covered	Formulary oral chemotherapy drugs follow the Generic Specialty drug benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible

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)	
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 15 visit limit/year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	0% coinsurance	40% coinsurance	120 maximum days per confinement
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	0% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% 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)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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, limit of 15 visits	• Hearing aids	• Routine eye care (Adult)
• Chiropractic care		

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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. For insured plans, contact the Wisconsin Office of the Commissioner of Insurance at 608-266-0103 / 1-800-236-8517, a consumer assistance program can help you file your appeal. For group health plans subject to ERISA, the US Dept. of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272), or www.dol.gov/ebsa/healthreform.

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Minimum Essential Coverage generally includes plans, 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.
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Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-398-9119.
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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.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$3,500
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:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$3,500
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:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	$3,500
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:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

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 or call 1-855-813-3888 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $3,500 Individual, $7,000 Family Out-of-network: $7,000 Individual, $14,000 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 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: $3,500 Individual, $7,000 Family Out-of-network medical/pharmacy: $14,000 Individual, $28,000 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/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.

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: No charge	Primary Office Visit: 40% coinsurance Convenience Care: 40% coinsurance	None
	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	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	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	40% 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	Formulary: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 40% coinsurance at retail, mail not covered Non-preferred: 40% coinsurance at retail, mail not covered	Days Supply: 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	0% coinsurance	40% coinsurance at retail, mail not covered	
	Non-preferred brand drugs	0% coinsurance	40% coinsurance at retail, mail not covered	
	Specialty drugs	0% coinsurance	40% coinsurance at retail, mail not covered	Formulary oral chemotherapy drugs follow the Generic Specialty drug benefit.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible

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)	
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	40% coinsurance	None
	Physician/surgeon fees	0% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	40% coinsurance	None
	Inpatient services	0% coinsurance	40% coinsurance	None
If you are pregnant	Office visits	No charge	40% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	40% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 15 visit limit/year
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	0% coinsurance	40% coinsurance	120 maximum days per confinement
	Durable medical equipment	0% coinsurance	40% coinsurance	None
	Hospice services	0% coinsurance	40% coinsurance	None
If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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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	• Infertility treatment	• Private-duty nursing
• Cosmetic surgery	• Long-term care	• Routine foot care
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(9 months of in-network pre-natal care and a hospital delivery)

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Specialist coinsurance	0%
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:
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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	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$3,500
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Primary care physician office visits (*including disease education*)
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Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	$3,500
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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:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
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The total Mia would pay is	**$2,800**

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Important Questions	Answers	Why This Matters:
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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: $3,500 Individual, $7,000 Family Out-of-network medical/pharmacy: $14,000 Individual, $28,000 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/newiselect 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.
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	Specialist visit	0% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge	40% coinsurance	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.
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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: 0% coinsurance Non-preferred: 0% coinsurance	Formulary: 40% coinsurance at retail, mail not covered Non-preferred: 40% coinsurance at retail, mail not covered	Days Supply: 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	0% coinsurance	40% coinsurance at retail, mail not covered	
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	Childbirth/delivery professional services	0% coinsurance	40% coinsurance	None
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If you need help recovering or have other special health needs	Home health care	0% coinsurance	40% coinsurance	In-network: 120 visit maximum; Out-of-network: 60 visit maximum
	Rehabilitation services	0% coinsurance	40% coinsurance	Out-of-network: 15 visit limit/year
	Habilitation services	Not covered	Not covered	None
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If your child needs dental or eye care	Children's eye exam	No charge	40% coinsurance	None
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Limits or exclusions	$60
The total Peg would pay is	**$3,560**

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

The plan's overall deductible	$3,500
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:

Cost Sharing	
Deductibles	$3,500
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$3,520**

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

The plan's overall deductible	$3,500
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:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**