



This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthpartners.com/gmtn or by calling 1-888-324-9722.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	\$0	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	Yes. \$65 Individual; \$130 Family retail pharmacy only.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. In-network: \$2,000 Individual, \$4,000 Family Pharmacy: \$1,500 Individual for mail order delivery only	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Pharmacy deductible, 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.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of in-network providers, see www.healthpartners.com/gmtn or call 1-888-324-9722.	If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about excluded services.

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If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-888-324-9722 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$30 copay	Not covered	_____none_____
	Specialist visit	\$30 copay	Not covered	_____none_____
	Other practitioner office visit	Acupuncture: \$30 copay Chiropractic: \$35 copay	Not covered	40 visit limit for chiropractic services
	Preventive care/screening/immunization	\$30 copay	Not covered	_____none_____
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	_____none_____
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	_____none_____
If you need drugs to treat your illness or condition	Generic drugs	\$15 copay retail; \$37 copay mail	50% of the Express Scripts discounted price for the medication	30 day supply retail/90 day supply mail order
	Preferred brand drugs	\$39 copay Retail; \$97 copay Mail	50% of the Express Scripts discounted price for the medication	
More information about prescription drug coverage is available through Express Scripts (Medco) 1-800-770-2815 www.express-scripts.com.				

General Mills: Murfreesboro

Coverage Period: 01/01/2013 - 12/31/2013

Summary of Coverage: What this Plan Covers & What it Costs

Coverage for: All Coverage Levels | Plan Type: PPO

Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
	Non-preferred brand drugs	\$63 copay Retail; \$157 copay Mail	50% of the Express Scripts discounted price for the medication	
	Specialty drugs	Retail: \$39 formulary \$63 non-formulary; Mail: \$97 formulary \$157 non-formulary	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$200 copay	Not covered	_____none_____
	Physician/surgeon fees	No charge	Not covered	_____none_____
If you need immediate medical attention	Emergency room services	\$200 copay	\$200 copay	_____none_____
	Emergency medical transportation	\$200 copay	\$200 copay	_____none_____
	Urgent care	\$75 copay	\$75 copay	_____none_____
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 copay per admit	Not covered	_____none_____
	Physician/surgeon fee	No charge	Not covered	_____none_____
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30 copay	Not Covered	_____none_____
	Mental/Behavioral health inpatient services	\$600 copay per admit	Not Covered	_____none_____
	Substance use disorder outpatient services	\$30 copay	Not Covered	_____none_____
	Substance use disorder inpatient services	\$600 copay per admit	Not Covered	_____none_____
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	Office visit copay initial visit, then 100%
	Delivery and all inpatient services	\$600 copay per admit	Not covered	_____none_____
If you need help recovering or have other special health	Home health care	20% coinsurance	Not covered	_____none_____
	Rehabilitation services	\$30 copay	Not covered	60 visit limit per year
	Habilitation services	\$30 copay	Not covered	60 visit limit per year

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Common Medical Event	Services You May Need	Your cost if you use a		Limitations & Exceptions
		In-Network Provider	Out-Of-Network Provider	
needs	Skilled nursing care	\$600 copay per admit	Not covered	180 Days per confinement
	Durable medical equipment	20% coinsurance	Not covered	
	Hospice service	20% coinsurance	Not covered	_____none_____
If your child needs dental or eye care	Eye exam	\$30 copay	Not covered	_____none_____
	Glasses	Not covered	Not covered	_____none_____
	Dental check-up	Not covered	Not covered	_____none_____

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
<ul style="list-style-type: none"> • Cosmetic surgery • Dental care (Adult) • Hearing aids 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine foot care • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> • Acupuncture • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Infertility treatment 	<ul style="list-style-type: none"> • Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-324-9722. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. You can contact your plan at 1-888-324-9722. You can contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. For questions about your rights, this notice, or assistance, you can contact your state insurance department at the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-296-4026 / 1-800-657-3602. Additionally, a consumer assistance program can help you file your appeal. Contact the following: MN Dept of Health at 651-201-5100 / 1-800-657-3916 or the MN Dept of Commerce at 651-296-4026 / 1-800-657-3602.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-888-324-9722

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-324-9722.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-888-324-9722.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-888-324-9722.

—————*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*—————

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different. Cost sharing or "Patient pays" amounts are based on self-only coverage.

Having a baby (normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,730
- Patient pays \$810

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$0
Copays	\$660
Coinsurance	\$0
Limits or exclusions	\$150
Total	\$810

Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,035
- Patient pays \$1,365

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$65
Copays	\$970
Coinsurance	\$250
Limits or exclusions	\$80
Total	\$1,365

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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