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 HealthPartners toll free 1-877-435-7613. 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 cciio.cms.gov or call 1-877-435-7613 to request a copy.

Important Questions	Answers		Why This Matters:
What is the overall deductible?	In-Network: $1,500 per person $3,000 per family	Out-of-Network: $3,000 per person $6,000 per 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 this plan, the overall family deductible must be met before the plan begins to pay. (Medical & Prescription Drug combined)
Are there services covered before you meet your deductible?	Yes. Preventive care is covered before you meet your deductible.		This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at 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: $5,400 per person $10,800 per family	Out-of-Network: $10,800 per person $21,600 per 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. **NOTE:** Individual with family coverage has an in-network out-of-pocket limit of $8,700. (Medical & Prescription Drug)
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, penalties for failure to obtain pre-authorization, prescription drug copayment assistance & 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 healthpartners.com/3M or call 1-877-435-7613 for a list of 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	20% coinsurance	35% coinsurance	——————none——————
	Specialist visit	20% coinsurance	35% coinsurance	——————none——————
	Preventive care/screening/ immunization	No charge	35% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	35% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	20% coinsurance	35% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at caremark.com and for specialty drugs at archimedesrx.com.	Generic drugs (Tier 1)	20% coinsurance • retail or mail order	35% coinsurance • retail • mail order - no coverage	• Retail: covers up to a 30-day supply. CVS Pharmacy stores cover up to a 90-day supply at mail order coinsurance rate. • Mail order: covers up to a 90-day supply. • Preauthorization is required for some medications. Contact CVS Caremark at 1-800-700-5257. • Out–of–pocket limit combined medical and prescription drug. See page 1 for dollar limits.
	Preferred brand drugs (Tier 2)	20% coinsurance • retail or mail order	35% coinsurance • retail • mail order – no coverage	
	Non-preferred brand drugs (Tier 3)	up to 80% coinsurance • retail or mail order	up to 80% coinsurance • retail • mail order – no coverage	
	Specialty drugs (Tier 4)	• Generic: 20% coinsurance, up to a max of $100 • Preferred brand & Non-preferred brand: same coinsurance as above	No coverage	Specialty drugs require clinical preauthorization and must be filled through Archimedes; covers up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	35% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	35% 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)	
	Carrum Health Center of Excellence benefit	No charge	No coverage	Certain orthopedic and spine procedures are covered at 100% after deductible waived when received through this program. Learn more at carrum.me/3M
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	20% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	35% coinsurance	Preauthorization is required.
	Physician/surgeon fees	20% coinsurance	35% coinsurance	——————none——————
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	35% coinsurance	——————none——————
	Inpatient services	20% coinsurance	35% coinsurance	——————none——————
If you are pregnant	Office visits	20% coinsurance	35% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	35% coinsurance	120 visits/year
	Rehabilitation services	20% coinsurance	35% coinsurance	60 visits/year. Includes physical therapy, speech therapy and occupational therapy.
	Habilitation services	20% coinsurance	35% coinsurance	
	Skilled nursing care	20% coinsurance	35% coinsurance	120 visits/year
	Durable medical equipment	20% coinsurance	35% coinsurance	Hearing aids: $3,000 per member every 3 yrs.
	Hospice services	20% coinsurance	35% coinsurance	Preauthorization is required.
If your child needs dental or eye care	Children's eye exam	$15 copay/visit	Not covered	One exam/year is available through VSP.
	Children's glasses	No coverage	No coverage	——————none——————
	Children's dental check-up	No coverage	No coverage	Dental coverage available through Delta Dental

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.)

- Cosmetic surgery
- Dental care (Adult)
- Long-term care
- Private-duty nursing
- Routine eye care (Adult) – coverage for routine eye care is available through VSP
- Routine foot care

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (subject to coverage limitations)
- Bariatric surgery
- Chiropractic care (subject to coverage limitations)
- Hearing Aids (subject to coverage limitations)
- Infertility. See progyny.com
- Non-emergency care when traveling outside the U.S. See healthpartners.com/getcareeverywhere.
- Weight loss programs

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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 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 on how 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
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 the 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 1-844-396-8946.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-844-396-8946.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-844-396-8946.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-844-396-8946.

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 copayment	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	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,260**

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 copayment	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,320**

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

The plan's overall deductible	$1,500
Specialist copayment	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$1,500
Copayments	$0
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.