PreferredOne®
INSURANCE COMPANY

2018 Benefit Summary
Individual/Family Plan

Balance Plus
PCP/Specialist Copay Plan

	In-Network Providers	Out-of-Network Providers
Individual		
Calendar Year Deductible	$3,000 per individual	$10,000 per individual
Calendar Year Out-of-Pocket Maximum	$6,450 per individual	Unlimited
-OR-		
Family		
Calendar Year Deductible	$6,000 per family ($3,000 per family member)	$20,000 per family
Calendar Year Out-of-Pocket Maximum	$12,900 per family ($6,450 per family member)	Unlimited
Partial Listing of Health Services		
Preventive Health Care Services		
As defined by PIC and required by the Affordable Care Act and its amendments or rules to coverages such as preventive exams, immunizations and cancer screenings.	Covered 100% *(deductible does not apply)*	Not covered
Office Visits (Sickness or Injury)		
Primary care physician (PCP) or specialist *The office visit applies to the copay all other Modalities/charges get applied to deductible/ coinsurance*	$25 PCP copay or $45 copay for specialist visit, first 3 visits combined, then 80% after deductible	Covered 50% after deductible
Diagnostic test (x-ray, blood work)	Covered 80% after deductible	Covered 50% after deductible
Imaging (CT/PET scans, MRIs)	Covered 80% after deductible	Covered 50% after deductible
Allergy injections	Covered 80% after deductible	Covered 50% after deductible
Online and convenience care	$10 copay for first 3 visit, than 80% after deductible	Not covered
Chiropractic services	See primary care (PCP) or specialist	Not covered
Urgent care clinic	Covered 80% after deductible	Covered 50% after deductible
Hospital Services		
Outpatient services	Covered 80% after deductible	Covered 50% after deductible
Inpatient services	Covered 80% after deductible	Covered 50% after deductible *(limited to 120 days per member per calendar year for all inpatient services combined)*
Emergency Care		
Hospital emergency room	Covered 80% after deductible	Covered 50% after deductible
Emergency ambulance	Covered 80% after deductible	Covered 50% after deductible
Maternity Care		
Prenatal/Postnatal	Covered 100% *(deductible does not apply)*	Not covered
Delivery and inpatient services	Covered 80% after deductible	Covered 50% after deductible

	In-Network Providers	Out-of-Network Providers
Prescription Drugs		
Up to a 31-day supply of prescription drugs or one type of insulin	Generic drugs tier 1: $10 copay Generic drugs tier 2: $30 copay Brand formulary drugs covered 80% after deductible Specialty and medical services drugs covered 50% after deductible Non-formulary drugs are not covered	Not covered
Mail order drugs for up to a 31-day supply		Not covered
Mental Health and Substance Use		
Outpatient	See primary care (PCP) or specialist	Covered 50% after deductible
Inpatient	Covered 80% after deductible	Covered 50% after deductible *(limited to 120 days per member per calendar year for all inpatient services combined)*
Durable Medical Equipment and Prosthetics		
Durable medical equipment & prosthetics	Covered 80% after deductible	Not covered
Home Health Services		
Home health care as an alternative to facility or clinic-based care	Covered 80% after deductible	Not covered
Skilled Nursing Facility Services		
Skilled rehabilitation, including room and board	Covered 80% after deductible	Not covered
Physical, Occupational and Speech Therapy	Covered 80% after deductible	Not covered
Pediatric Care (under 19 years of age)		
Eye exams	Covered 100% *(deductible does not apply)*	Not covered
Glasses or contacts *(One set of glasses or contacts per child per year)*	Covered 80% after deductible	Not covered
Preventive dental exams *(One visit every six months per child. Includes cleaning, x-rays, sealants)*	Covered 100% *(deductible does not apply)*	Not covered
Dental services *(Includes fillings, crowns & removal)*	Covered 80% after deductible	Not covered

Also included with your PreferredOne Benefits:

- Fitness Advantage - Up to $20 monthly credit for gym membership
- Healthy Mom and Baby Program
- Member Discount Programs
- Online Health Assessment
- Online Cost Tools

Visit **PreferredOne.com** for additional information on the programs listed above.

Services that are not covered include but not limited to: Acupuncture, Bariatric Surgery, Cosmetic Surgery, Adult Dental Care, Infertility Treatment, Long-Term Care (unless medically necessary in a skilled nursing facility), Private Duty Nursing, Adult Routine Eye Care, Routine Foot Care (except certain conditions), Weight Loss Programs (except preventive obesity counseling screening).

Pre-certification required; failure to obtain pre-certification may result in a reduction of non-participating provider benefits; call Customer Service.

This brochure summarizes your PreferredOne Insurance Company benefit coverage. For a complete description of benefits and exclusions, read your Individual Contract. Medical policies and pharmacy services information are available at PreferredOne.com. Please contact Customer Service at 763.847.4477 (Twin Cities area), 1.800.997.1750 (outside the metro area) or 763.847.4013 (TTY) for more information.