PreferredOne

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
PreferredHealth Expanded Bronze 30

Coverage Period: Beginning on or after 01/01/2021
Coverage for: Individual + Family | **Plan Type:** PPO

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, visit **www.PreferredOne.com/policy/24330**. 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 https://www.healthcare.gov/sbc-glossary/ or call 763.847.4477 / 800.997.1750 to request a copy. You can view the policy for this product by visiting **www.PreferredOne.com/policy/24330**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$8,550/$17,100** (individual/family-**$8,550** per family member) Out-of-network: **$15,000/$25,000** (individual/family) **Deductible** does not apply to in-network preventive care.	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. **Preventive care** services are 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 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: **$8,550/$17,100** (individual/family-**$8,550** per family member) Out-of-network: Unlimited	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?	**Premiums,** balance-billing charges from out-of-network **providers**, penalties on **preauthorization** services and health care this **plan** doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. A **network provider** is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the **provider** as total payment for the health care service.
Will you pay less if you use a network provider?	Yes. See **www.PreferredOne.com/preferredhealth** or call 1.800.997.1750 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
		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	$125 copay per visit	50% coinsurance	In-network online and convenience care covered at 100% (deductible does not apply).
	Specialist visit	$175 copay per visit	50% coinsurance	---------- None ----------
	Preventive care/screening/immunization	No charge (deductible does not apply)	Not covered	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. Some over-the-counter (OTC) drugs can be obtained with a prescription at the preventive level of coverage.
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 https://www.PreferredOne.com/Formulary-IND	Generic drugs	Retail and Mail: $35 copay	Not covered	Retail and mail: 31 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts. You will pay no more than $25 for designated insulin on the Preventive Drug list.
	Preferred brand drugs	Retail and Mail: 0% coinsurance	Not covered	Retail and mail: 31 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts. You will pay no more than $25 for designated insulin on the Preventive Drug list.
	Non-preferred brand drugs	Not covered	Not covered	None Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts.
	Specialty drugs	0% coinsurance	Not covered	31 day supply per prescription. Includes medical services drugs. Self administered injectable specialty drugs must be obtained from Fairview Specialty Pharmacy. Prior authorization is recommended. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts.

* For more information about limitations and exceptions, see the plan or policy document at www.preferredone.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	---------- None ----------
	Physician/surgeon fees	0% coinsurance	50% coinsurance	---------- None ----------
If you need immediate medical attention	Emergency room services	$1,000 copay for the first visit, then 0% coinsurance for any additional	$1,000 copay for the first visit, then 0% coinsurance for any additional	Out-of-network services apply to in-network deductible.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to in-network deductible.
	Urgent care	0% coinsurance	50% coinsurance	---------- None ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	$125 copay per visit	50% coinsurance	---------- None ----------
	Inpatient services	0% coinsurance	50% coinsurance	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. Includes residential treatment.
If you are pregnant	Office visits	No charge (deductible does not apply)	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance, deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	---------- None ----------
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	Pre-certification required--penalty applies.

* For more information about limitations and exceptions, see the plan or policy document at www.preferredone.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	Not covered	Maximum of 120 visit limit per year for combined in- and out-of-network home care and a maximum of 60 visits for out-of-network home care per year.
	Rehabilitation services	$125 copay per visit	Not covered	---------- None ----------
	Habilitation services	$125 copay per visit	Not covered	---------- None ----------
	Skilled nursing care	0% coinsurance	Not covered	Pre-certification required--penalty applies.
	Durable medical equipment	0% coinsurance	Not covered	Limits may apply.
	Hospice service	0% coinsurance	Not covered	---------- None ----------
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	Not covered	Limit 1 visit per child per year.
	Children's glasses	0% coinsurance	Not covered	Limit 1 set of glasses or conventional contact lenses per child per year.
	Children's dental check-up	Not covered	Not covered	---------- None ----------

* For more information about limitations and exceptions, see the plan or policy document at www.preferredone.com.

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.)

- Acupuncture
- Bariatric surgery
- Cosmetic Surgery (unless determined to be reconstructive)
- Dental care (Adults)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing (except ventilator dependents)
- Routine eye care (Adult)
- Routine foot care (except certain conditions)
- Weight loss programs (except preventive obesity counseling/screening)

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

- Chiropractic care
- Hearing aids (every 3 years, up to age 19)

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 the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform or the Minnesota Department of Commerce at 651.539.1600 / 1.800.657.3602. 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 a **grievance** for any reason to your **plan**. For more information about your rights, this notice, or assistance, you can contact PreferredOne Customer Service at 763.847.4477 / 800.997.1750, the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform or the Minnesota Department of Commerce at 651.539.1600 / 1.800.657.3602.

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 Coverage Meet the Minimum Value Standard? 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 763.847.4477 / 800.997.1750

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 763.847.4477 / 800.997.1750

Chinese (中文): 如果需要中文的帮助，请拨打这个号码 763.847.4477 / 800.997.1750

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 763.847.4477 / 800.997.1750

* For more information about limitations and exceptions, see the plan or policy document at www.preferredone.com.

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	**$8,550**
Specialist copayment	**$175**
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	$8,550
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$8,610

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

The plan's overall deductible	**$8,550**
Specialist copayment	**$175**
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	$900
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$2,430

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

The plan's overall deductible	**$8,550**
Specialist copayment	**$175**
Hospital (facility) copayment	**$1,000**
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	$1,700
Copayments	$1,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,800

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

PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company ("PIC") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

PIC:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.800.940.5049 (መስማት ለተሳናቸው: 763.847.4013).

ဟသူဉ်ဟ်သး– နမ့ါကတိၤ ကညီ ကျိာ်အယိ, နမၤန့ါ ကျိာ်အတ၊်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1.800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (TTY: 763.847.4013).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013). 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).