
 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/26003. 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/26003.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-network: \$3,000/\$6,000 (individual/family- \$3,000 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: \$6,900/\$13,800 (individual/family- \$6,900 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	20% coinsurance	50% coinsurance	----- None -----
	Specialist visit	20% coinsurance	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)	20% coinsurance	50% coinsurance	----- None -----
	Imaging (CT/PET scans, MRIs)	20% 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: 20% 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.
	Preferred brand drugs	Retail and Mail: 20% 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	50% 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)	20% coinsurance	50% coinsurance	----- None -----
	Physician/surgeon fees	20% coinsurance	50% coinsurance	----- None -----
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	Out-of-network services apply to in-network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network services apply to in-network deductible.
	Urgent care	20% coinsurance	50% coinsurance	----- None -----
If you have a hospital stay	Facility fee (e.g., hospital room)	20% 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	20% coinsurance	50% coinsurance	----- None -----
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	20% coinsurance	50% coinsurance	----- None -----
	Inpatient services	20% 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	20% coinsurance	50% coinsurance	----- None -----
	Childbirth/delivery facility services	20% coinsurance	50% coinsurance	Pre-certification required--penalty applies.
If you need help recovering or have other special health needs	Home health care	20% 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	20% coinsurance	Not covered	----- None -----
	Habilitation services	20% coinsurance	Not covered	----- None -----
	Skilled nursing care	20% coinsurance	Not covered	Pre-certification required--penalty applies.
	Durable medical equipment	20% coinsurance	Not covered	Limits may apply.
	Hospice service	20% coinsurance	Not covered	----- None -----

* 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 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	20% 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, kwijigo holne' 763.847.4477 / 800.997.1750

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](#) **\$3,000**
- Specialist coinsurance **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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,900
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,960

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- Specialist coinsurance **20%**
- Hospital (facility) coinsurance **20%**
- Other copayment **\$25**

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$2,300
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
The total Joe would pay is	\$2,630

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

- The [plan's](#) overall [deductible](#) **\$3,000**
- Specialist coinsurance **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
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In this example, Mia would pay:

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

