
 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 [PreferredOne.com](http://PreferredOne.com). 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 [PreferredOne.com](http://PreferredOne.com) or call 763.847.4477 / 800.997.1750 to request a copy. You can view the policy for this product by visiting [PreferredOne.com/policy/21608](http://PreferredOne.com/policy/21608).

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	In-network: <b>\$0/\$0</b> (individual/family). Out-of-network: <b>\$300/\$900</b> (individual/family).	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
<b>Are there services covered before you meet your deductible?</b>	Yes. <a href="#">Preventive care</a> services are covered before you meet your <a href="#">deductible</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without cost-sharing and before you meet your <a href="#">deductible</a> . See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
<b>What is the out-of-pocket limit for this plan?</b>	In-network: <b>\$1,200/\$3,600</b> (individual/family). Out-of-network: <b>\$4,000</b> /individual.	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket</a> limits until the overall family <a href="#">out-of-pocket limit</a> has been met.
<b>What is not included in the out-of-pocket limit?</b>	<a href="#">Premiums</a> , balance-billing charges, penalties on <a href="#">preauthorization</a> services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
<b>Will you pay less if you use a network provider?</b>	Yes. See <a href="http://PreferredOne.com">PreferredOne.com</a> or call 1.800.997.1750 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the plan's <a href="#">network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays (balance billing). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
<b>Do you need a referral to see a specialist?</b>	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$25 copay/visit	45% coinsurance after deductible	Convenience care \$10 copay/visit. 20 out-of-network chiropractic visits per year.
	Specialist visit	\$25 copay/visit	45% coinsurance after deductible	----- None -----
	Preventive care/screening/immunization	No charge	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.
<b>If you have a test</b>	Diagnostic test (x-ray, blood work)	No charge	45% coinsurance after deductible	----- None -----
	Imaging (CT/PET scans, MRIs)	20% coinsurance	45% coinsurance after deductible	----- None -----
<b>If you need drugs to treat your illness or condition</b>  More information about <a href="#">prescription drug coverage</a> is available at <a href="#">PreferredOne.com</a>	Generic drugs	Retail: \$15 copay. Mail: \$30 copay.	Retail: 45% coinsurance after deductible Mail: Not covered	Retail: 31 day supply per prescription. Mail: 93 day supply per prescription.
	Preferred brand drugs	Retail: \$15 copay. Mail: \$30 copay.	Retail: 45% coinsurance after deductible Mail: Not covered	Retail: 31 day supply per prescription. Mail: 93 day supply per prescription.
	Non-preferred brand drugs	Retail: \$30 copay. Mail: \$60 copay.	Retail: 45% coinsurance after deductible Mail: Not covered	Retail: 31 day supply per prescription. Mail: 93 day supply per prescription.
	Specialty drugs	20% coinsurance; member pays up to maximum of \$200 per prescription unit or refill.	Retail: 45% coinsurance after deductible Mail: Not covered	31 day supply per prescription. Self administered injectable specialty drugs must be obtained from Fairview Specialty Pharmacy. Prior authorization is recommended.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	45% coinsurance after deductible	----- None -----
	Physician/surgeon fees	20% coinsurance	45% coinsurance after deductible	----- None -----
<b>If you need immediate medical attention</b>	Emergency room services	\$100 copay/visit	\$100 copay/visit	----- None -----
	Emergency medical transportation	20% coinsurance	20% coinsurance	----- None -----
	Urgent care	\$25 copay/visit	\$25 copay/visit	----- None -----

\* For more information about limitations and exceptions, see the plan or policy document at 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	
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	20% coinsurance	45% coinsurance after deductible	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
	Physician/surgeon fees	20% coinsurance	45% coinsurance after deductible	----- None -----
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Outpatient services	\$25 copay/visit	45% coinsurance after deductible	----- None -----
	Inpatient services	20% coinsurance	45% coinsurance after deductible	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
<b>If you are pregnant</b>	Office visits	No charge	No charge	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	45% coinsurance after deductible	----- None -----
	Childbirth/delivery facility services	20% coinsurance	45% coinsurance after deductible	Pre-certification required--penalty applies.
<b>If you need help recovering or have other special health needs</b>	Home health care	Therapies: \$25 copay IV: No charge	45% coinsurance after deductible	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	\$25 copay/visit	45% coinsurance after deductible	20 out-of-network visits per year combined with chiropractic and habilitation visits.
	Habilitation services	\$25 copay/visit	45% coinsurance after deductible	
	Skilled nursing care	20% coinsurance	45% coinsurance after deductible	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
	Durable medical equipment	20% coinsurance	45% coinsurance after deductible	Limits may apply.
	Hospice service	No charge	Not covered	----- None -----

\* For more information about limitations and exceptions, see the plan or policy document at 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	Not covered	Limit 1 visit per child per year.
	Children's glasses	Not covered	Not covered	----- None -----
	Children's dental check-up	No charge	Not covered	----- None -----

\* For more information about limitations and exceptions, see the plan or policy document at 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](#).)

- Cosmetic Surgery (unless determined to be reconstructive)
- Long-term care
- Private-duty nursing (except ventilator dependents)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (every 3 years, up to age 19)
- Infertility treatment
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)

## 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](http://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](http://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](http://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

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	20%
■ 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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$1,260</b>

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	20%
■ 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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$800
Coinsurance	\$400
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$1,230</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ Specialist copayment	\$15
■ Hospital (facility) coinsurance	20%
■ 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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$150
Coinsurance	\$300
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$450</b>

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