**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**. 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.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | Combined in-network and out-of-network: **$1,400/$2,800** (individual/family). Family deductible is non-embedded. 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: **$1,400/$2,800** and Out-of-network: **$6,900/$13,800** (individual/family). Combined in and out of network. Family out-of-pocket limit is non-embedded. | 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. |
| **What is not included in the out-of-pocket limit?** | Premiums, balance-billing charges, 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. |
| **Will you pay less if you use a network provider?** | Yes. See **www.PreferredOne.com** 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 | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Specialist visit | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Preventive care/screening/immunization | No charge (deductible does not apply) | No charge (deductible does not apply) | ---------- None ---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| **If you need drugs to treat your illness or condition**<br><br>More information about prescription drug coverage is available at https://www.PreferredOne.com/pharmacy-information/formulary | Generic drugs | Retail: No charge after deductible.<br>Mail: No charge after deductible. | Not covered | Retail: 31 day supply per prescription.<br>Mail: 90 day supply per prescription. |
| | Preferred brand drugs | Retail: No charge after deductible.<br>Mail: No charge after deductible. | Not covered | Retail: 31 day supply per prescription.<br>Mail: 90 day supply per prescription. |
| | Non-preferred brand drugs | Retail: No charge after deductible.<br>Mail: No charge after deductible. | Not covered | Retail: 31 day supply per prescription.<br>Mail: 90 day supply per prescription. |
| | Specialty drugs | No charge after deductible | Not covered | 31 day supply per prescription. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Physician/surgeon fees | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| **If you need immediate medical attention** | Emergency room services | No charge after deductible | No charge after deductible | ---------- None ---------- |
| | Emergency medical transportation | No charge after deductible | No charge after deductible | ---------- None ---------- |
| | Urgent care | No charge after deductible | 20% coinsurance after deductible | ---------- 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 you have a hospital stay** | Facility fee (e.g., hospital room) | No charge after deductible | 20% coinsurance after deductible | Pre-certification required--penalty applies. |
| | Physician/surgeon fees | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Inpatient services | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| **If you are pregnant** | Office visits | No charge (deductible does not apply) | No charge (deductible does not apply) | ---------- None ---------- |
| | Childbirth/delivery professional services | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Childbirth/delivery facility services | No charge after deductible | 20% coinsurance after deductible | Pre-certification required--penalty applies. |
| **If you need help recovering or have other special health needs** | Home health care | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Rehabilitation services | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Habilitation services | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Skilled nursing care | No charge after deductible | 50% coinsurance after deductible | Inpatient hospital services are limited to a out-of-network maximum of 120 calendar days per covered person per plan year. Pre-certification required--penalty applies. |
| | Durable medical equipment | No charge after deductible | 20% coinsurance after deductible | Prior authorization required if durable medical equipment or prosthesis exceeds $5,000. |
| | Hospice service | No charge after deductible | Not covered | ---------- None ---------- |
| **If your child needs dental or eye care** | Children's eye exam | No charge (deductible does not apply) | No charge (deductible does not apply) | Limit 1 visit per covered person per year. |
| | Children's glasses | Not covered | Not covered | ---------- None ---------- |
| | 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
- Dental care (Adults)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- 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.)**

- Hearing aids (every 3 years, up to age 19)
- Infertility treatment
- Routine eye care

## 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 the agency is the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /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 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 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform.

## 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** | **$1400** |
| Specialist coinsurance | **0%** |
| 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** | **$12,800** |

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $1,460 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1400** |
| Specialist coinsurance | **0%** |
| 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** | **$7,400** |

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Joe would pay is** | $1,430 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$1400** |
| Specialist coinsurance | **0%** |
| Hospital (facility) coinsurance | **0%** |
| 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** | **$1,900** |

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,400 |
| Copayments | $0 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,400 |

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