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**. 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** or call 763.847.4477 / 800.997.1750 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: **$5,000/$10,000** (individual/family). Out-of-network: **$10,000/$20,000** (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: **$5,000/$10,000** (individual/family). Out-of-network: **$15,000/$30,000** (individual/family).	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, 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 **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	30% coinsurance after deductible	---------- None ----------
	Specialist visit	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Preventive care/screening/immunization	No charge (deductible does not apply)	Not covered	---------- None ----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Imaging (CT/PET scans, MRIs)	No charge after deductible	30% coinsurance after deductible	---------- None ----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at **PreferredOne.com**	Generic drugs	Retail: No charge after deductible Mail: No charge after deductible	Retail: No charge after deductible Mail: Not covered	Retail/Maintenance Pharmacy: Up to a 102 day supply
	Preferred brand drugs	Retail: No charge after deductible Mail: No charge after deductible	Retail: 30% coinsurance after deductible Mail: Not covered	---------- None ----------
	Non-preferred brand drugs	Not covered	Not covered	---------- None ----------
	Specialty drugs	No charge after deductible	Retail: 30% coinsurance after deductible Mail: Not covered	---------- None ----------
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Physician/surgeon fees	No charge after deductible	30% 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	30% coinsurance after deductible	---------- 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 you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Physician/surgeon fees	No charge after deductible	30% coinsurance after deductible	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Inpatient services	No charge after deductible	30% 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	30% coinsurance after deductible	---------- None ----------
	Childbirth/delivery facility services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
If you need help recovering or have other special health needs	Home health care	No charge after deductible	50% coinsurance after deductible	Limited to 120 visits per covered person per calendar year.
	Rehabilitation services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Habilitation services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Skilled nursing care	No charge after deductible	30% coinsurance after deductible	Coverage is limited to 120 days per confinement.
	Durable medical equipment	No charge after deductible	30% coinsurance after deductible	Limited to 1 wig per year for Alopecia Areata.
	Hospice service	No charge after deductible	30% coinsurance after deductible	---------- None ----------
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	30% coinsurance after deductible	---------- None ----------
	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 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
- Dental care (Adults)
- 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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Hearing aids (every 3 years, up to age 19)
- Infertility treatment
- 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 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

* For more information about limitations and exceptions, see the plan or policy document at 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	**$5000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$5,060

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

The plan's overall deductible	**$5000**
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	$5,000
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$5,030

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

The plan's overall deductible	**$5000**
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	$1,900
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$1,900

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