**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **PreferredOne.com** or by calling **763.847.4477 / 800.997.1750**.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | In-network: **$1500/$4000** (individual/family)<br>Out-of-network: **$4500/$12000**<br>Deductible does not apply to in-network preventive care.<br>Family **deductible** is non-embedded. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | In-network: **$6350/$12700** (individual/family)<br>Out-of-network: **$19200/$38400**<br>Family **out-of-pocket** is non-embedded. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | **Premiums, balance-billed** charges and health care this plan does not cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for specifc services, such as office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, go to **PreferredOne.com** or call Customer Service at 763.847.4477 / 800.997.1750. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, copayments and coinsurance amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | 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 | 40% coinsurance | ---------- None ---------- |
| | Specialist visit | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Other practitioner office visit | 20% coinsurance | 40% coinsurance | Out-of-network visit limits may apply. |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance | ---------- None ---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at **PreferredOne.com** | Generic drugs | Retail and mail: 20% coinsurance | Retail: 40% coinsurance<br><br>Mail: Not covered | Retail: 31 day supply per prescription.<br>Mail: 93 day supply per prescription. |
| | Preferred brand drugs | Retail and mail: 20% coinsurance | Retail: 40% coinsurance<br>Mail: Not covered | Retail: 31 day supply per prescription.<br>Mail: 93 day supply per prescription. |
| | Non-preferred brand drugs | Retail and mail: 20% coinsurance | Retail: 40% coinsurance<br>Mail: Not covered | Retail: 31 day supply per prescription.<br>Mail: 93 day supply per prescription. |
| | Specialty drugs | 20% coinsurance | 40% coinsurance | 31 day supply per prescription. |

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Physician/surgeon fees | 20% coinsurance | 40% 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 | 40% coinsurance | ---------- None ---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | 120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. |
| | Physician/surgeon fee | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Mental/Behavioral health inpatient services | 20% coinsurance | 40% coinsurance | 120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. |
| | Substance use disorder outpatient services | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Substance use disorder inpatient services | 20% coinsurance | 40% coinsurance | 120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. |
| **If you are pregnant** | Prenatal care | No charge | No charge | ---------- None ---------- |
| | Postnatal care | No charge | No charge | ---------- None ---------- |
| | Delivery and all inpatient services | 20% coinsurance | 40% coinsurance | Pre-certification required--penalty applies. |

| Common Medical Event | Services You May Need | Your Cost If You Use a | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network Provider | Out-of-Network Provider | |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 50% coinsurance | 120 visits per member, per year. |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Habilitation services | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | 120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. |
| | Durable medical equipment | 20% coinsurance | 50% coinsurance | ---------- None ---------- |
| | Hospice service | 20% coinsurance | 40% coinsurance | ---------- None ---------- |
| **If your child needs dental or eye care** | Eye exam | No charge | 40% coinsurance | Limit 1 visit per child per year. |
| | Glasses | 20% coinsurance | Not covered | Limit 1 set of glasses per child per year. |
| | Dental check-up | No charge | 40% coinsurance | Limit 1 visit per child every 6 months. |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adults)
- Infertility treatment
- Long-term care (except medically necessary care in a skilled nursing facility)
- 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** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Hearing aids (every 3 years, up to age 19)
- Non-emergency care when traveling outside the U.S.

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact PreferredOne Customer Service at 763.847.4477 / 800.997.1750. You may also contact your state insurance department, the U.S. Department of Labor, EBSA at 1.866.444.3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1.877.267.2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact PreferredOne Customer Service at 763.847.4477 / 800.997.1750. You can contact the U.S. Department of Labor, EBSA at 1.866.444.3272 or www.dol.gov/ebsa/healthreform. You may also contact your state insurance department: MN Dept of Health at 651.201.5100 / 1.800.657.3916 or the MN Dept of Commerce at 651.296.2488 / 1.800.657.3602.

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Spanish (Español) Para obtener asistencia en español llame al 763.847.4477 / 800.997.1750

----------To see examples of how this plan might cover costs for a sample medical situation, see the next page.----------

# About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

## Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,290
- **Patient pays** $2,250

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,500 |
| Copays | $0 |
| Coinsurance | $600 |
| Limits or exclusions | $150 |
| **Total** | **$2,250** |

## Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,060
- **Patient pays** $2,340

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,500 |
| Copays | $0 |
| Coinsurance | $760 |
| Limits or exclusions | $80 |
| **Total** | **$2,340** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- The patient is enrolled for single coverage.
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.