**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: **$2,000/$4,000** (individual/family); Out-of-network: **$4,000/$8,000** (individual/family). **Deductible** does not apply to in-network preventive care. | 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: **$2,000/$4,000** (individual/family). Combined in and out-of-network: **$5,000/$10,000** (individual/family). Family **out-of-pocket limit** 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 specific coverage limits, such as limits on the number of 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 6. 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 | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Specialist visit | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Other practitioner office visit | No charge after deductible | 40% coinsurance after deductible | Out-of-network Chiropractic, 15 visits per year. |
| | Preventive care/screening/ immunization | No charge (deductible does not apply) | 40% coinsurance after deductible | ---------- None ---------- |
| **If you have a test** | Diagnostic test (x-ray, blood work) | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Imaging (CT/PET scans, MRIs) | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |

| Common Medical Event | Services You May Need | Your Cost If You Use a In-Network Provider | Your Cost If You Use a Out-of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br>More information about **prescription drug coverage** is available at **PreferredOne.com** | Generic drugs | Retail: $12 copay.<br>Mail: $30 copay.<br>(deductible does not apply) | Retail: 40% coinsurance (deductible does not apply).<br>Mail: Not covered. | Retail: 31 day supply per prescription.<br>Mail: 93 day supply per prescription. |
| | Preferred brand drugs | Retail: $40 copay.<br>Mail: $100 copay.<br>(deductible does not apply) | Retail: 40% coinsurance (deductible does not apply).<br>Mail: Not covered. | Retail: 31 day supply per prescription.<br>Mail: 93 day supply per prescription. |
| | Non-preferred brand drugs | Retail: Greater of $80 copay or 50% coinsurance.<br>Mail: Greater of $200 copay or 50% coinsurance.<br>(deductible does not apply) | Retail: 40% coinsurance (deductible does not apply).<br>Mail: Not covered. | Retail: 31 day supply per prescription.<br>Mail: 93 day supply per prescription. |
| | Specialty drugs | No charge after deductible | 40% coinsurance after deductible | 31 day supply per prescription. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Physician/surgeon fees | No charge after deductible | 40% 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 | 40% coinsurance after deductible | ---------- None ---------- |

| 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 a hospital stay** | Facility fee (e.g., hospital room) | No charge after deductible | 40% coinsurance after deductible | 120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. |
| | Physician/surgeon fee | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Mental/Behavioral health inpatient services | No charge after deductible | 40% coinsurance after deductible | 120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. |
| | Substance use disorder outpatient services | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Substance use disorder inpatient services | No charge after deductible | 40% coinsurance after deductible | 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 (deductible does not apply) | No charge (deductible does not apply) | ---------- None ---------- |
| | Postnatal care | No charge (deductible does not apply) | No charge (deductible does not apply) | ---------- None ---------- |
| | Delivery and all inpatient services | No charge after deductible | 40% coinsurance after deductible | 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 | No charge after deductible | 50% coinsurance after deductible | ---------- None ---------- |
| | Rehabilitation services | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| | Habilitation services | No charge after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Skilled nursing care | No charge after deductible | 40% 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 | No charge after deductible | 50% coinsurance after deductible | ---------- None ---------- |
| | Hospice service | No charge after deductible | 40% coinsurance after deductible | ---------- None ---------- |
| **If your child needs dental or eye care** | Eye exam | No charge (deductible does not apply) | 40% coinsurance after deductible | Limit 1 visit per child per year. |
| | Glasses | No charge after deductible | Not covered | Limit 1 set of glasses or contacts per child per year. |
| | Dental check-up | No charge (deductible does not apply) | 40% coinsurance after deductible | 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.)**

- Bariatric surgery
- Cosmetic surgery
- Dental care (Adults)
- Infertility treatment
- Long-term care (except medically necessary care in a skilled nursing facility)
- Private-duty nursing
- Routine foot care
- Weight loss programs

**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.)**

- Acupuncture (if prescribed for rehabilitation purposes)
- Chiropractic care
- Hearing aids (every 3 years, up to age 19)
- Non-emergency care when traveling outside the U.S.
- Routine eye care

## 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 the PreferredOne Customer Service Department at 763.847.4477 / 800.997.1750. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration 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 the PreferredOne Customer Service Department at 763.847.4477 / 800.997.1750. If your plan is subject to ERISA, you may contact the U. S. Department of Labor, Employee Benefits Security Administration at 1.866.444.3272 or www.dol.gov/ebsa/healthreform. If your coverage is insured, you may also contact your state insurance department.

## 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** $5,370
- **Patient pays** $2,170

**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 | $2,000 |
| Copays | $20 |
| Coinsurance | $0 |
| Limits or exclusions | $150 |
| **Total** | **$2,170** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,840
- **Patient pays** $2,560

**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 | $2,000 |
| Copays | $480 |
| Coinsurance | $0 |
| Limits or exclusions | $80 |
| **Total** | **$2,560** |

# 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.