**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 and out-of-network: **$750/$1,500** (individual/family). | 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?** | Medical out-of-pocket limit: **$1,500/$3,000** (individual/family), combined in and out-ofnetwork.<br><br>Prescription Drug out-of-pocket limit: **$4,000/ $8,000** (individual/family), combined in and out-of-network. | 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?** | Medical out-of-pocket limit: Premiums, balance-billed charges and health care this plan does not cover.<br><br>Prescription Drug out-of-pocket limit: additional charges for dispense as written prescriptions. | 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. |

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **Do you need a referral** to see a **specialist?** | No. | You can see the **specialist** you choose without a **referral**. |



* For more information about limitations and exceptions, see the plan or policy document at PreferredOne.com.

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 | $25 copay/visit (deductible does not apply) | 30% coinsurance after deductible | ---------- None ---------- |
| | Specialist visit | $25 copay/visit (deductible does not apply) | 30% coinsurance after deductible | 20% coinsurance after deductible, with a maximum of $20 for in-network chiropractic services |
| | Preventive care/screening/immunization | No charge (deductible does not apply) | 30% coinsurance after deductible | Includes related lab work. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance after deductible | 30% coinsurance after deductible | ---------- None ---------- |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance after deductible | 30% 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 | Tier 1 Retail: 20% coinsurance up to a $20 maximum per prescription unit or refill Mail: $10 copay | Not covered. | Limited to a 90 day supply for mail order. |
| | Preferred brand drugs | Tier 2 Retail: 30% coinsurance up to a $40 maximum per prescription unit or refill Mail: $30 copay | Not covered. | Limited to a 90 day supply for mail order. |
| | Non-preferred brand drugs | Tier 3 Retail: 40% coinsurance up to a $80 maximum per prescription unit or refill Mail: $60 copay | Not covered. | Retail: up to 93 day supply per prescription. Mail: 93 day supply per prescription. |
| | Specialty drugs | Above applicable copay will apply. | Not covered. | Limited to a 30 day supply; must be purchased through a specialty pharmacy. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance after deductible | 30% coinsurance after deductible | Prior authorization recommended. |
| | Physician/surgeon fees | 20% coinsurance 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 need immediate medical attention** | Emergency room services | $150 copay/visit (deductible does not apply) | $150 copay/visit (deductible does not apply) | ---------- None ---------- |
| | Emergency medical transportation | 20% coinsurance after deductible | 20% coinsurance after deductible | ---------- None ---------- |
| | Urgent care | $25 copay/visit (deductible does not apply) | 30% coinsurance after deductible | ---------- None ---------- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance after deductible | 30% coinsurance after deductible | Pre-admission certification must be obtained to avoid a 50% penalty up to a maximum of $750. |
| | Physician/surgeon fees | 20% coinsurance after deductible | 30% coinsurance after deductible | ---------- None ---------- |
| **If you have mental health, behavioral health, or substance abuse needs** | Outpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | ---------- None ---------- |
| | Inpatient services | 20% coinsurance after deductible | 30% coinsurance after deductible | Pre-admission certification must be obtained to avoid a 50% penalty up to a maximum of $750. |
| **If you are pregnant** | Office visits | No charge (deductible does not apply) | 30% coinsurance after deductible | ---------- None ---------- |
| | Childbirth/delivery professional services | 20% coinsurance after deductible | 30% coinsurance after deductible | ---------- None ---------- |
| | Childbirth/delivery facility services | 20% coinsurance after deductible | 30% coinsurance after deductible | Pre-admission certification must be obtained to avoid a 50% penalty up to a maximum of $750. |



* 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 need help recovering or have other special health needs** | Home health care | 20% coinsurance after deductible | 20% coinsurance after deductible | Prior approval is required. |
| | Rehabilitation services | $25 copay/visit (deductible does not apply) | 20% coinsurance after deductible | Excludes occupational therapy supplies. |
| | Habilitation services | $25 copay/visit (deductible does not apply) | 20% coinsurance after deductible | Excludes occupational therapy supplies. |
| | Skilled nursing care | 20% coinsurance after deductible | 30% coinsurance after deductible | Pre-admission certification must be obtained to avoid a 50% penalty up to a maximum of $750. |
| | Durable medical equipment | 20% coinsurance after deductible | 20% coinsurance after deductible | Rental cannot exceed the purchase price. |
| | Hospice service | 20% coinsurance after deductible | 20% coinsurance after deductible | Pre-admission certification must be obtained to avoid a 50% penalty up to a maximum of $750. |
| **If your child needs dental or eye care** | Children's eye exam | Not covered | Not covered | ---------- 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 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 • Cosmetic surgery | • Hearing aids<br>• Long-term care | • Non-emergency care when traveling outside the U.S.<br>• Routine eye care |
| **Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)** | | |
| • Chiropractic care | • Infertility treatment | |

**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** | **$750** |
| Specialist copayment | **$25** |
| Hospital (facility) coinsurance | **20%** |
| Other coinsurance | **20%** |

**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 | $750 |
| Copayments | $0 |
| Coinsurance | $750 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | $1,560 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$750** |
| Specialist copayment | **$25** |
| Hospital (facility) coinsurance | **20%** |
| Other coinsurance | **20%** |

**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 | $750 |
| Copayments | $700 |
| Coinsurance | $100 |
| *What isn't covered* | |
| Limits or exclusions | $30 |
| **The total Joe would pay is** | $1,580 |

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

| | |
|---|---|
| **The plan's overall deductible** | **$750** |
| Specialist copayment | **$25** |
| Hospital (facility) coinsurance | **20%** |
| Other coinsurance | **20%** |

**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 | $750 |
| Copayments | $150 |
| Coinsurance | $150 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | $1,050 |

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