
 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, call 1-800-997-1750 or visit us at <https://www.preferredone.com/individualplan/IndBrochure.pdf>. 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 www.healthcare.gov/sbc-glossary or call 1-800-318-2596 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers \$4,900 Individual / \$9,800 Family. For out-of-network providers \$9,800 Individual / \$19,600 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. Services are covered before you meet your deductible. Contact Insurance provider for more details.	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 preventative services without cost sharing and before you meet your deductible . See a list of covered preventative services at https://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?	For network providers \$4,900 Individual / \$9,800 Family. For out-of-network providers Not Applicable Individual / Not Applicable 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, and health care this plan doesn't cover.	This plan does not have an out-of-pocket limit on your expenses.
Will you pay less if you use a network provider?	Yes. See http://providerguide.preferredone.com/Default.asp?Network=OA300 or call 1-800-997-1750 for a list of 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 .

 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
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 Copay and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Specialist visit	\$35 Copay and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Preventive care/screening/immunization	Copay: No Charge and Coinsurance: No Charge	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
If you have a test	Diagnostic test (x-ray, blood work)	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Imaging (CT/PET scans, MRIs)	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://secure.preferredone.com/shared/pharmacy/NationalPreferredAlphaWithContraceptives.pdf	Generic drugs (Tier 1)	\$10 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Preferred brand drugs (Tier 2)	\$75 Copay and Coinsurance: Not Applicable	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Non-preferred brand drugs (Tier 3)	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Specialty drugs (Tier 4)	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 100% Coinsurance	—————none—————
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Physician/surgeon fees	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
If you need immediate medical attention	Emergency room care	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and Coinsurance: No Charge after deductible	—————none—————
	Emergency medical transportation	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and Coinsurance: No Charge after deductible	—————none—————
	Urgent care	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Physician/surgeon fee	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$35 Copay and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Inpatient services	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
If you are pregnant	Office visits	Please contact the health insurance company for more information	Please contact the health insurance company for more information	Please contact the health insurance company for more information
	Childbirth/delivery professional services	Please contact the health insurance company for more information	Please contact the health insurance company for more information	Please contact the health insurance company for more information
	Childbirth/delivery facility services	Please contact the health insurance company for more information	Please contact the health insurance company for more information	Please contact the health insurance company for more information

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Rehabilitation services	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and Coinsurance: No Charge after deductible	—————none—————
	Habilitation services	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	—————none—————
	Skilled nursing care	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Durable medical equipment	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Hospice services	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
If your child needs dental or eye care	Children's eye exam	Copay: No Charge and Coinsurance: No Charge	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Children's glasses	Copay: Not Applicable and Coinsurance: No Charge after deductible	Copay: Not Applicable and 100% Coinsurance	Limitations and Exceptions apply. Please contact the health insurance company for more information.
	Children's dental check-up	Copay: No Charge and Coinsurance: No Charge	Copay: Not Applicable and 40% Coinsurance after deductible	Limitations and Exceptions apply. Please contact the health insurance company for more information.

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
- Basic Dental Care - Adult
- Infertility Treatment
- Long-Term/Custodial Nursing Home Care
- Major Dental Care - Adult
- Orthodontia - Adult
- Routine Dental Services (Adult)
- Routine Eye Exam (Adult)

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
- Cosmetic Surgery
- Hearing Aids
- Private-Duty Nursing
- Routine Foot Care
- Weight Loss Programs

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: State Department of Insurance at 651-539-1500 and Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272). 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, contact: State Department of Insurance at 651-539-1500.

Does this plan provide Minimum Essential Coverage? Please contact the health insurance company for more information.

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 plan meet Minimum Value Standards? Please contact the health insurance company for more information.

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](#).

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

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](#) \$ 4,900
- [Specialist copayment](#) \$35

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 \$ 7,540

In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 0
Copayments	\$ 0
Coinsurance	\$ 0
<i>What isn't covered</i>	
Limits or exclusions	\$ 0
The total Peg would pay is	\$ 0

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

- The plan's overall [deductible](#) \$ 4,900
- [Specialist copayment](#) \$35

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 \$ 5,400

In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$ 0
Copayments	\$ 0
Coinsurance	\$ 0
<i>What isn't covered</i>	
Limits or exclusions	\$ 0
The total Joe would pay is	\$ 0

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

- The plan's overall [deductible](#) \$ 4,900
- [Specialist copayment](#) \$35

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:

<i>Cost Sharing</i>	
Deductibles	\$ 0
Copayments	\$ 0
Coinsurance	\$ 0
<i>What isn't covered</i>	
Limits or exclusions	\$ 0
The total Mia would pay is	\$ 0

Note: These numbers assume the patient does not participate in the [plan's](#) wellness program. If you participate in the [plan's](#) wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-997-1750.