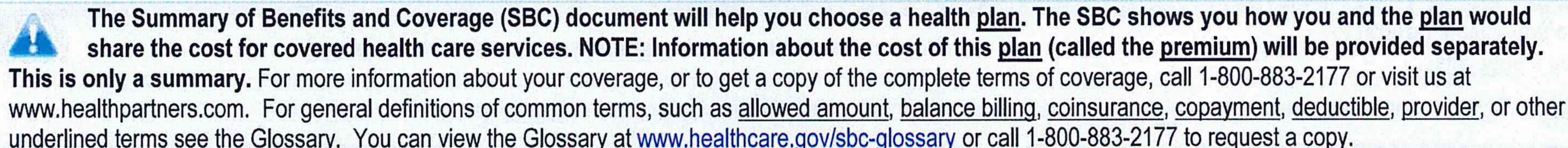
Current Plan - Single Election - 2020-21

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

HealthPartners:3900-100 HSA Silver - Perform

Coverage for: Single/Family | **Plan Type:** PPO



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 1-800-883-2177 or visit us at www.healthpartners.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 www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $3,900 Individual/$7,800 Family contract Out-of-network: $10,000 Individual/$20,000 Family contract	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Coinsurance marked with * under What You Will Pay and benefits with no charge are not subject to 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 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?	In-network medical/pharmacy: $3,900 Individual/$7,800 Family contract Out-of-network medical/pharmacy: $30,000 Individual/$60,000 Family contract	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, the overall family out-of-pocket limit must be met.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges (unless balanced billing is prohibited), 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 http://www.healthpartners.com/performse or call 1-800-883-2177 for a list of in-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 in-network 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	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/genericsadvantagerx	Generic drugs	Formulary: 0% coinsurance Non-formulary: Not covered	Formulary: 50% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail/ 93 day supply mail order
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	0% coinsurance	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
	Emergency medical	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-

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)	
	transportation			network deductible.
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	120 visit limit
	Rehabilitation services	0% coinsurance	50% coinsurance	None
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 120 day maximum
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	0% coinsurance	Not covered	Limit of one pair of eyeglasses or contact lenses per year.
	Children's dental check-up	No charge	50% coinsurance	None

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 • Bariatric surgery • Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery • Dental care (Adult)	• Hearing aids(Adult) • Infertility treatment • Long-term care	• Private-duty nursing • Routine foot care • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Non-emergency care when traveling outside the U.S.	• 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: Your plan at 1-800-883-2177, or the MN Dept of Health at 651-201-5100 / 1-800-657-3916, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. 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.

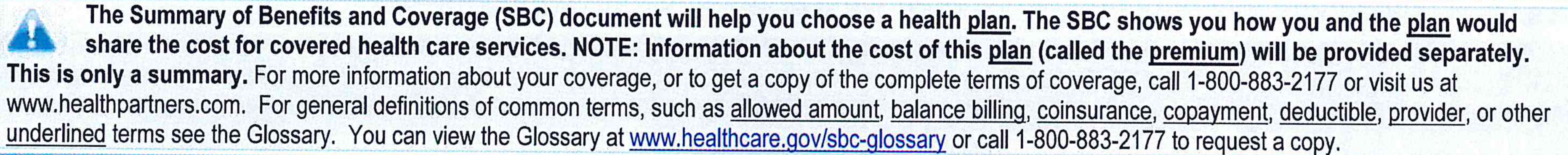
Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your 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: Your plan at 1-800-883-2177 or the MN Dept of Health at 651-201-5100 / 1-800-657-3916.

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 plan meet Minimum Value Standards? 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 1-866-398-9119.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-883-2177.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

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



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 1-800-883-2177 or visit us at www.healthpartners.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 www.healthcare.gov/sbc-glossary or call 1-800-883-2177 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: $4,100 Individual/$8,200 Family Out-of-network: $10,000 Individual/$20,000 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. Coinsurance marked with * under What You Will Pay and benefits with no charge are not subject to 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 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?	In-network medical/pharmacy: $4,100 Individual/$8,200 Family Out-of-network medical/pharmacy: $30,000 Individual/$60,000 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?	Premium, balance-billed charges (unless balanced billing is prohibited), 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 http://www.healthpartners.com/performse or call 1-800-883-2177 for a list of in-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 in-network 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: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Primary Office Visit: 0% coinsurance Convenience Care: 0% coinsurance virtuwell: 0% coinsurance	Primary Office Visit: 50% coinsurance Convenience Care: 50% coinsurance	None
	Specialist visit	0% coinsurance	50% coinsurance	None
	Preventive care/screening/ immunization	No charge	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.healthpartners.com/genericsadvantagerx	Generic drugs	Formulary: 0% coinsurance Non-formulary: Not covered	Formulary: 50% coinsurance at retail, mail not covered Non-formulary: Not covered	31 day supply retail/ 93 day supply mail order
	Formulary brand drugs	0% coinsurance	50% coinsurance at retail, mail not covered	
	Non-formulary brand drugs	Not covered	Not covered	
	Specialty drugs	0% coinsurance	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.
	Urgent care	0% coinsurance	0% coinsurance	Out-of-network services apply to the in-network deductible.

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)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance use disorder services	Outpatient services	0% coinsurance	50% coinsurance	None
	Inpatient services	0% coinsurance	50% coinsurance	None
If you are pregnant	Office visits	No charge	50% coinsurance	Depending on the type of services, a copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	None
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	None
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	120 visit limit
	Rehabilitation services	0% coinsurance	50% coinsurance	None
	Habilitation services	0% coinsurance	50% coinsurance	None
	Skilled nursing care	0% coinsurance	50% coinsurance	Limited to 120 day maximum
	Durable medical equipment	0% coinsurance	50% coinsurance	None
	Hospice services	0% coinsurance	50% coinsurance	Respite care is limited to 5 days per episode and respite care and continuous care combined are limited to 30 days.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	None
	Children's glasses	0% coinsurance	Not covered	Limit of one pair of eyeglasses or contact lenses per year.
	Children's dental check-up	No charge	50% coinsurance	None

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
- Bariatric surgery
- Cosmetic surgery with the exception of port wine stain removal and reconstructive surgery
- Dental care (Adult)
- Hearing aids(Adult)
- Infertility treatment
- Long-term care
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- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
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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: Your plan at 1-800-883-2177 or the MN Dept of Health at 651-201-5100 / 1-800-657-3916.

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 plan meet Minimum Value Standards? 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.

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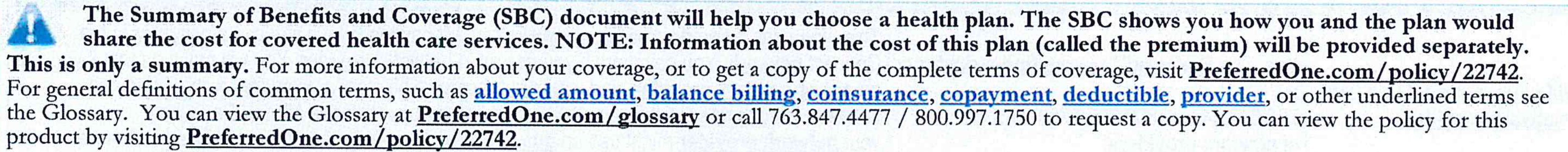
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-883-2177.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-883-2177.

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

PreferredOne

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
G.PIC.3000.100.HSA ST (Gold)

Coverage Period: Beginning on or after 01/01/2020
Coverage for: Individual + Family | **Plan Type:** HSA



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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/policy/22742**. 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/glossary** or call 763.847.4477 / 800.997.1750 to request a copy. You can view the policy for this product by visiting **PreferredOne.com/policy/22742**.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network providers: **$3,000/$6,000** (individual/family-**$2,800** per family member) In-network family deductible is embedded. SuperTier Connect providers: **$1,400/$2,800** (individual/family) Out-of-network providers: **$7,500/$15,000** (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?	In-network providers: **$3,000/$6,000** (individual/family-**$3,000** per family member) In-network family out-of-pocket limit is embedded. SuperTier Connect providers: **$1,400/$2,800** (individual/family) Out-of-network providers: **$24,000/$48,000** (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 from out-of-network providers, 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. A network provider is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the provider as total payment for the health care service.

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Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **PreferredOne.com/find-a-doctor** or call 763.847.4477/1.800.997.1750 for a list of **network providers**.	This **plan** uses a tiered **provider network**. You will pay the least if you use a **provider** in the Connect **network**. You pay more if you use an in-network **provider**. 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**.

* 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	0% coinsurance	50% coinsurance	Includes in-network online and convenience care. 15 out-of-network chiropractic visits per year combined with rehabilitation and habilitation visits.
	Specialist visit	0% coinsurance	50% coinsurance	---------- None ----------
	Preventive care/screening/immunization	No charge (deductible does not apply)	50% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Some over-the-counter (OTC) drugs can be obtained with a prescription at the preventive level of coverage.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	---------- None ----------
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	---------- None ----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at PreferredOne.com/pharmacy-information/formulary	Generic drugs	Retail: 0% coinsurance Mail: 0% coinsurance	Retail: 50% coinsurance Mail: Not covered	Retail: 31 day supply per prescription. Mail: 93 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts.
	Preferred brand drugs	Retail: 0% coinsurance Mail: 0% coinsurance	Retail: 50% coinsurance Mail: Not covered	Retail: 31 day supply per prescription. Mail: 93 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts.
	Non-preferred brand drugs	Retail: 0% coinsurance Mail: Not covered	Retail: 50% coinsurance Mail: Not covered	Applies to non-formulary prescriptions. Retail: 31 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts.
	Specialty drugs	0% coinsurance	Not covered	31 day supply per prescription. Self administered injectable specialty drugs must be obtained from Fairview Specialty Pharmacy. Prior authorization is recommended. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, coinsurance, copays or out-of-pocket amounts.

* 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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	---------- None ----------
	Physician/surgeon fees	0% coinsurance	50% coinsurance	---------- None ----------
If you need immediate medical attention	Emergency room services	0% coinsurance	0% coinsurance	Out-of-network services apply to in-network deductible.
	Emergency medical transportation	0% coinsurance	0% coinsurance	Out-of-network services apply to in-network deductible.
	Urgent care	0% coinsurance	50% coinsurance	---------- None ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	0% coinsurance	50% coinsurance	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	0% coinsurance	50% coinsurance	---------- None ----------
	Inpatient services	0% coinsurance	50% coinsurance	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies. Includes residential treatment.
If you are pregnant	Office visits	No charge (deductible does not apply)	No charge (deductible does not apply)	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, coinsurance, or deductible may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	---------- None ----------
	Childbirth/delivery facility services	0% coinsurance	50% coinsurance	Pre-certification required--penalty applies.

* 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	0% coinsurance	50% coinsurance	120 visits per member, per year.
	Rehabilitation services	0% coinsurance	50% coinsurance	15 out-of-network visits per year combined with chiropractic and habilitation visits.
	Habilitation services	0% coinsurance	50% coinsurance	15 out-of-network visits per year combined with chiropractic and rehabilitation visits.
	Skilled nursing care	0% coinsurance	50% coinsurance	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
	Durable medical equipment	0% coinsurance	50% coinsurance	Limits apply.
	Hospice service	0% coinsurance	50% coinsurance	---------- None ----------
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	50% coinsurance	Limit 1 visit per child per year.
	Children's glasses	0% coinsurance	Not covered	Limit 1 set of glasses or conventional contact lenses per child per year.
	Children's dental check-up	0% coinsurance	Not covered	Limit 1 visit per child every 6 months.

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 • Bariatric surgery • Cosmetic Surgery (unless determined to be reconstructive)	• Dental care (Adults) • Infertility treatment • Long-term care	• 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.)		
• Chiropractic care	• Hearing aids (every 3 years, up to age 19)	• 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.