




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](http://www.preferredone.com). For 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](http://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 <a href="#">deductible</a> ?	In-network: \$3,000/\$6,000 (individual/family-\$3,000 per family member) Out-of-network: \$15,000/\$25,000 (individual/family) <a href="#">Deductible</a> does not apply to in-network <a href="#">preventive care</a> .	Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. <a href="#">Preventive care</a> services are covered before you meet your deductible.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	In-network: \$6,900/\$13,800 (individual/family-\$6,900 per family member) Out-of-network: Unlimited	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	Premiums, balance-billing charges from out-of- <a href="#">network providers</a> , penalties on <a href="#">preauthorization</a> services and health care this <a href="#">plan</a> doesn't cover.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> . A <a href="#">network provider</a> is prohibited from billing an enrollee for any amount in excess of the allowable amount the health carrier has contracted for with the <a href="#">provider</a> as total payment for the health care service.
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.preferredone.com/prefhealth">www.preferredone.com/prefhealth</a> or call 1.800.997.1750 for a list of <a href="#">network providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	No.	You can see the <a href="#">specialist</a> you choose without a <a href="#">referral</a> .

 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 (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	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Specialist</a> visit	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	<a href="#">Preventive care/screening/immunization</a>	No charge ( <a href="#">deductible</a> does not apply)	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> 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)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Imaging (CT/PET scans, MRIs)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at <a href="https://www.preferredone.com/Formulary-IND/?y=2023">https://www.preferredone.com/Formulary-IND/?y=2023</a>	Generic drugs	Retail and Mail: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Retail and mail: 31 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, <a href="#">coinsurance</a> , copays or out-of-pocket amounts. You will pay no more than \$25 for designated insulin on the Preventive Drug list.
	Preferred brand drugs	Retail and Mail: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Retail and mail: 31 day supply per prescription. Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, <a href="#">coinsurance</a> , copays or out-of-pocket amounts. You will pay no more than \$25 for designated insulin on the Preventive Drug list.
	Non-preferred brand drugs	Retail and Mail: 20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	None Charges which you are not legally obligated to pay (e.g. manufacturer coupons) cannot be used to satisfy deductible, <a href="#">coinsurance</a> , copays or out-of-pocket amounts.
	<a href="#">Specialty drugs</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	31 day supply per prescription. Includes medical services drugs. Self administered injectable <a href="#">specialty drugs</a> 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, <a href="#">coinsurance</a> , copays or out-of-pocket amounts.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need immediate medical attention	<a href="#">Emergency room services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Out-of-network services apply to in-network deductible.
	<a href="#">Emergency medical transportation</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Out-of-network services apply to in-network deductible.
	<a href="#">Urgent care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	120 days per member, per year for all out-of-network inpatient services combined. Pre-certification required--penalty applies.
	Physician/surgeon fees	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Inpatient services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	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 ( <a href="#">deductible</a> does not apply)	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, copayment, <a href="#">coinsurance</a> , <a href="#">deductible</a> may apply.
	Childbirth/delivery professional services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	None
	Childbirth/delivery facility services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	50% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Pre-certification required--penalty applies.
If you need help recovering or have other special health needs	<a href="#">Home health care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Maximum of 120 visit limit per year for combined in- and out-of-network home care and a maximum of 60 visits for out-of-network home care per year.
	Rehabilitation services	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	None
	<a href="#">Habilitation services</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	None
	<a href="#">Skilled nursing care</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Pre-certification required--penalty applies.
	<a href="#">Durable medical equipment</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Limits may apply.
	<a href="#">Hospice service</a>	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No charge ( <a href="#">deductible</a> does not apply)	Not covered	Limit 1 visit per child per year.
	Children's glasses	20% <a href="#">coinsurance</a> after <a href="#">deductible</a>	Not covered	Limit 1 set of glasses or conventional contact lenses per child per year.
	Children's dental check-up	Not covered	Not covered	None

### Excluded Services & Other Covered Services:

Services your <a href="#">plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Dental care (Adults)</li> <li>• Non-emergency care when traveling outside the U.S.</li> <li>• Routine foot care (except certain conditions)</li> </ul>	<ul style="list-style-type: none"> <li>• Bariatric surgery</li> <li>• Infertility treatment</li> <li>• Private-duty nursing (except ventilator dependents)</li> <li>• Weight loss programs (except preventive obesity counseling/screening)</li> </ul>	<ul style="list-style-type: none"> <li>• Cosmetic Surgery (unless determined to be reconstructive)</li> <li>• Long-term care</li> <li>• Routine eye care (Adult)</li> </ul>

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)	
• Chiropractic care	• Hearing aids

### 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](http://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](http://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](http://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

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

### Does this plan meet the 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 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 763.847.4477 / 800.997.1750]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 763.847.4477 / 800.997.1750]

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

## 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 <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	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)

<b>Total Example Cost</b>	<b>\$12,700</b>
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#### In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	<b>\$3000</b>
<a href="#">Copayments</a>	<b>\$0</b>
<a href="#">Coinsurance</a>	<b>\$1900</b>
What isn't covered	
Limits or Exclusions	<b>\$60</b>
<b>The total Peg would pay is</b>	<b>\$4,960</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">copayment</a>	\$25

#### This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)  
[Diagnostic tests](#) (blood work)  
[Prescription drugs](#)  
[Durable Medical Equipment \(glucose meter\)](#)

<b>Total Example Cost</b>	<b>\$5,600</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	<b>\$2300</b>
<a href="#">Copayments</a>	<b>\$300</b>
<a href="#">Coinsurance</a>	<b>\$0</b>
What isn't covered	
Limits or Exclusions	<b>\$30</b>
<b>The total Joe would pay is</b>	<b>\$2,630</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,000
■ <a href="#">Specialist coinsurance</a>	20%
■ Hospital (facility) <a href="#">coinsurance</a>	20%
■ Other <a href="#">coinsurance</a>	20%

#### This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)  
[Diagnostic tests](#) (x-ray)  
[Durable medical equipment](#) (crutches)  
[Rehabilitation services](#) (physical therapy)

<b>Total Example Cost</b>	<b>\$2,800</b>
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#### In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	<b>\$2800</b>
<a href="#">Copayments</a>	<b>\$0</b>
<a href="#">Coinsurance</a>	<b>\$0</b>
What isn't covered	
Limits or Exclusions	<b>\$0</b>
<b>The total Mia would pay is</b>	<b>\$2,800</b>

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

## PreferredOne Insurance Company Nondiscrimination Notice

PreferredOne Insurance Company (“PIC”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity. PIC does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

PIC:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, you can file a grievance with:

Grievance Specialist  
PreferredOne Insurance Company  
PO Box 59212  
Minneapolis, MN 55459-0212  
Phone: 1.800.940.5049 (TTY: 763.847.4013)  
Fax: 763.847.4010  
Email: [customerservice@preferredone.com](mailto:customerservice@preferredone.com)

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Assistance Services

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.800.940.5049 (TTY: 763.847.4013).

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1.800.940.5049 (TTY: 763.847.4013).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.800.940.5049 (TTY: 763.847.4013).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.800.940.5049 (TTY: 763.847.4013)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.800.940.5049 (телетайп: 763.847.4013).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.800.940.5049 (TTY: 763.847.4013).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም አገልግሎት ደርጅቶቹ በገዳ ሊያገኙት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ፡ 1.800.940.5049 (መስማት ለተሳናገው: 763.847.4013)።

တၢ်သ့ၣ်တၢ်သး- နမူကတိၤ ကညီ ကျိၣ်အယိၣ်, နမူနာ ကျိၣ်အတၢ်မၤစၢၤလၢ တလၢတၢ်ဘျုးတၢ်တၢ်တၢ်, နီတၢ်ဘၣ်သ့ၣ်န့ၣ်လီၤ. ကိၤ800.940.5049 (TTY: 763.847.4013).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.800.940.5049 (TTY: 763.847.4013).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយភ្នែកភាសា ដោយមិនគិតលុយ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1.800.940.5049 (TTY: 763.847.4013)។

ملحوظة: إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1.800.940.5049 (رقم هاتف الصم والبكم: 763.847.4013).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.800.940.5049 (ATS: 763.847.4013).

주의: 한국어를 사용하지는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.800.940.5049 (TTY: 763.847.4013) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.800.940.5049 (TTY: 763.847.4013).