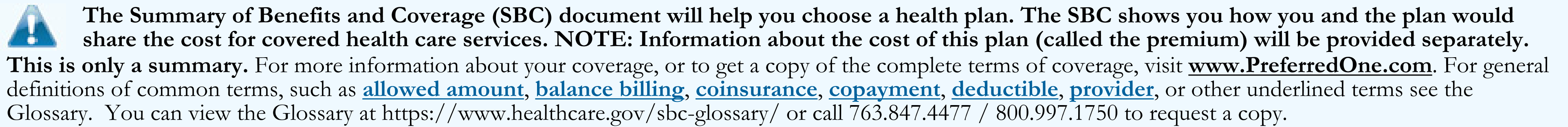
Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services
Richfield Public Schools ISD #280 - PLAN B - $2,700 Deductible Medical Option

Coverage Period: Beginning on or after 07/01/2021
Coverage for: Individual + Family | **Plan Type:** PPO

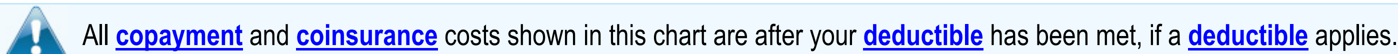


The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, 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?	In-network for Individual/Family: **$2,700/ $5,400** (**$2,700** per family member). Out-of-network for Individual/Family: **$3,950/ $7,900** (**$3,950** per family member). Family deductible is embedded. In-network and out-of-network deductibles are combined. Deductible does not apply to in-network preventive care.	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: **$2,700/$5,400** (**$2,700** per family member) Out-of-network: **$7,900** per individual Family out-of-pocket is embedded. Combined in and out-of-network: **$7,900** per individual.	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, 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.

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	Yes. See **www.PreferredOne.com/complete** 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.
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 www.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	No charge after deductible	30% coinsurance after deductible	Out-of-network Chiropractic, 15 visits per year.
	Specialist visit	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Preventive care/screening/immunization	No charge (deductible does not apply)	30% coinsurance after deductible	---------- None ----------
If you have a test	Diagnostic test (x-ray, blood work)	No charge (deductible does not apply)	30% coinsurance after deductible	---------- None ----------
	Imaging (CT/PET scans, MRIs)	No charge (deductible does not apply)	30% coinsurance after deductible	---------- None ----------
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.maxorplus.com 1-800-687-0707	Generic drugs	Preferred Pharmacy*: Retail: $7 copay Mail: $14 copay **Non-Preferred Pharmacy: Retail $13 copay	Retail: The greater of 40% or $26 copay (deductible does not apply) Mail: Not applicable	93-day supply per prescription Retail: 1 copay applies per 31-day supply. *Preferred Pharmacy-All Pharmacies except CVS/ Walgreens **Non-preferred Pharmacies-CVS/ Walgreens Pharmacies
	Preferred brand drugs	Preferred Pharmacy*: Retail: $11 copay Mail: $22 copay. **Non-Preferred Pharmacy: Retail $22 copay	Retail: The greater of 40% or $26 copay (deductible does not apply) Mail: Not applicable	93-day supply per prescription Retail: 1 copay applies per 31-day supply. *Preferred Pharmacy-All Pharmacies except CVS/ Walgreens **Non-preferred Pharmacies-CVS/ Walgreens Pharmacies
	Non-preferred brand drugs	Preferred Pharmacy*: Retail: $26 copay Mail: $52 copay. **Non-Preferred Pharmacy: Retail $44 copay	Retail: The greater of 40% or $26 copay (deductible does not apply) Mail: Not applicable	93-day supply per prescription Retail: 1 copay applies per 31-day supply. *Preferred Pharmacy-All Pharmacies except CVS/ Walgreens **Non-preferred Pharmacies-CVS/ Walgreens Pharmacies
	Specialty drugs	20% coinsurance to a maximum of $200 per prescription	40% coinsurance after deductible	31 day supply per prescription. Mail: Not covered
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Physician/surgeon fees	No charge after deductible	30% coinsurance after deductible	---------- None ----------

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	No charge after deductible	Refer to the in-network benefit column	---------- None ----------
	Emergency medical transportation	No charge (deductible does not apply)	Refer to the in-network benefit column	---------- None ----------
	Urgent care	No charge after deductible	Refer to the in-network benefit column	---------- None ----------
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge after deductible	30% coinsurance after deductible	Pre-certification required.
	Physician/surgeon fees	No charge after deductible	30% coinsurance after deductible	---------- None ----------
If you have mental health, behavioral health, or substance abuse needs	Outpatient services	Group therapy: 10% coinsurance (deductible does not apply) Individual therapy: 20% coinsurance (deductible does not apply)	30% coinsurance after deductible	---------- None ----------
	Inpatient services	No charge after deductible	30% coinsurance after deductible	Pre-certification required.
If you are pregnant	Office visits	No charge (deductible does not apply)	30% coinsurance after deductible	---------- None ----------
	Childbirth/delivery professional services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Childbirth/delivery facility services	No charge after deductible	30% coinsurance after deductible	Pre-certification required.

* For more information about limitations and exceptions, see the plan or policy document at www.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	No charge after deductible	30% coinsurance after deductible	Limited to 122 visits per covered person per calendar year.
	Rehabilitation services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Habilitation services	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Skilled nursing care	No charge after deductible	30% coinsurance after deductible	Pre-certification required. Coverage is limited to services that are provided within 30 days of discharge from a hospital in which the covered person was confined for not less than 3 consecutive days.
	Durable medical equipment	No charge after deductible	30% coinsurance after deductible	---------- None ----------
	Hospice service	No charge after deductible	30% coinsurance after deductible	---------- None ----------
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	30% coinsurance after deductible	---------- 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.)		
• Cosmetic surgery • Dental care (Adults)	• 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.)		
• Acupuncture • Bariatric surgery	• Chiropractic care • Hearing aids (every 3 years, up to age 19)	• Infertility treatment • Routine eye care

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

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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** **$2,700**
- Specialist coinsurance **0%**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	$2,760

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

- **The plan's overall deductible** **$2,700**
- Specialist coinsurance **0%**
- Hospital (facility) coinsurance **0%**
- Other copayment **$11**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,900
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$30
The total Joe would pay is	$2,230

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

- **The plan's overall deductible** **$2,700**
- Specialist coinsurance **0%**
- Hospital (facility) coinsurance **0%**
- Other coinsurance **0%**

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	$2,710

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