Rosholt School District
Outline of Benefits
Signature HMO HDHP
Effective July 1, 2023

Benefit Accumulator	**Plan Year (July 1 - June 30)**	
PROVISION/BENEFIT	**PARTICIPATING PROVIDERS What you pay**	**NON-PARTICIPATING PROVIDERS What you pay**
Deductible - Non-Embedded HDHP *- one person, in a family, can satisfy the family deductible amount noted below*		
Single	$1,500	Not Applicable
Family	$3,000	Not Applicable
Coinsurance		
Coinsurance	0%	Not Applicable
Annual Out-of-Pocket Limit (includes deductible and coinsurance) - Non-Embedded HDHP - *one person, in a family, can satisfy the family out-of-pocket amount noted below*		
Single	$1,500	Not Applicable
Family	$3,000	Not Applicable

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Ambulance services**	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Behavioral health Therapy services Outpatient/Transitional Services Inpatient services**	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Not Covered
Chiropractic office visit/manipulations	Deductible and Coinsurance	Not Covered
Contraceptives	0%	Not Covered
Diagnostic x-ray and laboratory services**	Deductible and Coinsurance	Not Covered
Durable medical equipment**	Deductible and Coinsurance	Not Covered
Emergency room - visit charge only	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Emergency room services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Home care - limited to 40 visits per year	Deductible and Coinsurance	Not Covered
Hospital inpatient services**	Deductible and Coinsurance	Not Covered
Immunizations	0%	Not Covered
Injections - outpatient	Deductible and Coinsurance	Not Covered
Kidney disease treatment	Deductible and Coinsurance	Not Covered
Maternity services	Deductible and Coinsurance	Not Covered
Medical supplies	Deductible and Coinsurance	Not Covered
Nutritional counseling	0%	Not Covered
Office visits - visit charge only Primary Care Practitioner Specialist	 Deductible and Coinsurance Deductible and Coinsurance	Not Covered
Preventive Care Services* (includes routine eye exams for children and adults)	0%	Not Covered
Surgical services	Deductible and Coinsurance	Not Covered
Telehealth visits (through MDLIVE) General Counseling Psychiatry Dermatology	0%	Not Covered

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Benefit Accumulator	**Plan Year (July 1 - June 30)**	
PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Therapy visits (physical/speech/occupational Office setting Home or outpatient hospital setting	Deductible and Coinsurance	Not Covered
Transplant Services**	Deductible and Coinsurance	Not Covered
All other health care services - unless otherwise stated in your plan	Deductible and Coinsurance	Not Covered
Covered Drugs and Covered Supplies		
Prescription Drugs and certain diabetic supplies ***Drugs and covered supplies dispensed by a non-participating pharmacy are not covered***		
Prescription are subject to deductible - **after deductible**, the following copayments would apply:		
	Retail pharmacy 30-day supply	**Retail Pharmacy/Mail Order 31 - 90 day supply**
Tier 1:	$10	$20
Tier 2:	$30	$60
Tier 3:	$60	$120
Specialty Drugs**:	25%	N/A
Rx Out-of-Pocket Maximum *(Embedded)* :	Per Person: $1,000 Per Family: $2,000	
Preventive drugs - as required by the Affordable Care Act and defined in the Plan Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (Deductible waived)	
Limitations	Retail and Home Delivery: 90-day supply Specialty drugs and chemotherapy drugs: 30-day supply Smoking Cessation: Limited to 180-day supply per calendar year	
Mandatory generic and Step therapy	Applicable	
Specialty Drugs**	Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.	

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PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Deductible - Embedded HDHP		
Per Person	$3,000	Not Applicable
Per Family	$6,000	Not Applicable
Coinsurance		
Coinsurance	0%	Not Applicable
Annual Out-of-Pocket Limit (includes deductible and coinsurance) - Embedded HDHP		
Per Person	$3,000	Not Applicable
Per Family	$6,000	Not Applicable

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Ambulance services**	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Behavioral health Therapy services Outpatient/Transitional Services Inpatient services**	 Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Not Covered
Chiropractic office visit/manipulations	Deductible and Coinsurance	Not Covered
Contraceptives	0%	Not Covered
Diagnostic x-ray and laboratory services**	Deductible and Coinsurance	Not Covered
Durable medical equipment**	Deductible and Coinsurance	Not Covered
Emergency room - visit charge only	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Emergency room services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Home care - limited to 40 visits per year	Deductible and Coinsurance	Not Covered
Hospital inpatient services**	Deductible and Coinsurance	Not Covered
Immunizations	0%	Not Covered
Injections - outpatient	Deductible and Coinsurance	Not Covered
Kidney disease treatment	Deductible and Coinsurance	Not Covered
Maternity services	Deductible and Coinsurance	Not Covered
Medical supplies	Deductible and Coinsurance	Not Covered
Nutritional counseling	0%	Not Covered
Office visits - visit charge only Primary Care Practitioner Specialist	 Deductible and Coinsurance Deductible and Coinsurance	Not Covered
Preventive Care Services* (includes routine eye exams for children and adults)	0%	Not Covered
Surgical services	Deductible and Coinsurance	Not Covered
Telehealth visits (through MDLIVE) General Counseling Psychiatry Dermatology	0%	Not Covered

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PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Therapy visits (physical/speech/occupational Office setting Home or outpatient hospital setting	Deductible and Coinsurance	Not Covered
Transplant Services**	Deductible and Coinsurance	Not Covered
All other health care services - unless otherwise stated in your plan	Deductible and Coinsurance	Not Covered
Covered Drugs and Covered Supplies		
Prescription Drugs and certain diabetic supplies ***Drugs and covered supplies dispensed by a non-participating pharmacy are not covered***		
Prescription are subject to deductible - **after deductible**, the following copayments would apply:		
	Retail pharmacy 30-day supply	**Retail Pharmacy/Mail Order 31 - 90 day supply**
Tier 1:	$10	$20
Tier 2:	$30	$60
Tier 3:	$60	$120
Specialty Drugs**:	25%	N/A
Rx Out-of-Pocket Maximum *(Embedded)* :	Per Person: $500 Per Family: $1,000	
Preventive drugs - as required by the Affordable Care Act and defined in the Plan Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (Deductible waived)	
Limitations	Retail and Home Delivery: 90-day supply Specialty drugs and chemotherapy drugs: 30-day supply Smoking Cessation: Limited to 180-day supply per calendar year	
Mandatory generic and Step therapy	Applicable	
Specialty Drugs**	Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.	

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Rosholt School District
Outline of Benefits
Freedom POS HDHP
Effective July 1, 2023

Benefit Accumulator	**Plan Year (July 1 - June 30)**	
PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Deductible - Non-Embedded HDHP - *one person, in a family, can satisfy the family deductible amounts noted below* *(Note: In-network and out-of-network deductible amounts do not credit toward each other)*		
Single	$1,500	$3,000
Family	$3,000	$6,000
Coinsurance		
Coinsurance	0%	20%
Annual Out-of-Pocket Limit (includes deductible and medical coinsurance) - Non-Embedded HDHP - *one person, in a family, can satisfy the family amounts noted below* *(Note: In-network and out-of-network out-of-pocket amounts do not credit toward each other)*		
Single	$1,500	$4,500
Family	$3,000	$9,000

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Ambulance services**	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Behavioral health		
Therapy services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient/Transitional Services	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services**	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance
Emergency room - visit charge only	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Emergency room services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Home care - limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	Deductible and Coinsurance
Injections - outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	Deductible and Coinsurance
Office visits - visit charge only		
Primary Care Practitioner	Deductible and Coinsurance	Deductible and Coinsurance
Specialist	Deductible and Coinsurance	
Preventive Care Services* (includes routine eye exams for children and adults)	0%	Deductible and Coinsurance
Surgical services	Deductible and Coinsurance	Deductible and Coinsurance

	Rosholt School District Outline of Benefits Freedom POS HDHP Effective July 1, 2023	
Benefit Accumulator	**Plan Year (July 1 - June 30)**	
PROVISION/BENEFIT	**PARTICIPATING PROVIDERS** **What you pay**	**NON-PARTICIPATING PROVIDERS** **What you pay*** **
Telehealth visits (through MDLIVE) General Counseling Psychiatry Dermatology	0%	Not Covered
Therapy visits (physical/speech/occupational Office setting Home or outpatient hospital setting	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services**	Deductible and Coinsurance	Deductible and Coinsurance
All other health care services - unless otherwise stated in your plan	Deductible and Coinsurance	Deductible and Coinsurance
Covered Drugs and Covered Supplies		
Prescription Drugs and certain diabetic supplies ***Drugs and covered supplies dispensed by a non-participating pharmacy are not covered***		
Prescription are subject to deductible - **after deductible**, the following copayments would apply:		
	Retail pharmacy **30-day supply**	**Retail Pharmacy/Mail Order** **31 - 90 day supply**
Tier 1:	$10	$20
Tier 2:	$30	$60
Tier 3:	$60	$120
Specialty Drugs**:	25%	N/A
Rx Out-of-Pocket Maximum *(Embedded)*:	Per Person: $1,000 Per Family: $2,000	
Preventive drugs - as required by the Affordable Care Act and defined in the Plan Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (Deductible waived)	
Limitations	Retail and Home Delivery: 90-day supply Specialty drugs and chemotherapy drugs: 30-day supply Smoking Cessation: Limited to 180-day supply per calendar year	
Mandatory generic and Step therapy	Applicable	
Specialty Drugs**	Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.	

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***Non-participating provider services are subject to our non-participating provider reimbursement value. That value fee may be less than what the health care provider bills and you may be responsible for the difference between what the health care provider bills and out non-participating provider reimbursement value (often referred to as "balance billing"). **These amounts do not apply to the overall deductible and out-of-pocket maximums noted above.**

Rosholt School District
Outline of Benefits
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Benefit Accumulator	**Plan Year (July 1 - June 30)**	
PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Deductible - Embedded HDHP *(Note: In-network and out-of-network deductible amounts do not credit toward each other)*		
Per Person	$3,000	$6,000
Per Family	$6,000	$12,000
Coinsurance		
Coinsurance	0%	20%
Annual Out-of-Pocket Limit (includes deductible and medical coinsurance) - Embedded HDHP *(Note: In-network and out-of-network out-of-pocket amounts do not credit toward each other)*		
Per Person	$3,000	$7,000
Per Family	$6,000	$14,000

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Ambulance services**	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Behavioral health		
Therapy services	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient/Transitional Services	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services**	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance
Emergency room - visit charge only	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Emergency room services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Home care - limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	Deductible and Coinsurance
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Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	Deductible and Coinsurance
Office visits - visit charge only		Deductible and Coinsurance
Primary Care Practitioner	Deductible and Coinsurance	
Specialist	Deductible and Coinsurance	
Preventive Care Services* (includes routine eye exams for children and adults)	0%	Deductible and Coinsurance
Surgical services	Deductible and Coinsurance	Deductible and Coinsurance

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PROVISION/BENEFIT	**PARTICIPATING PROVIDERS What you pay**	**NON-PARTICIPATING PROVIDERS What you pay*** **
Telehealth visits (through MDLIVE) General Counseling Psychiatry Dermatology	0%	Not Covered
Therapy visits (physical/speech/occupational Office setting Home or outpatient hospital setting	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services**	Deductible and Coinsurance	Deductible and Coinsurance
All other health care services - unless otherwise stated in your plan	Deductible and Coinsurance	Deductible and Coinsurance
Covered Drugs and Covered Supplies		
Prescription Drugs and certain diabetic supplies ***Drugs and covered supplies dispensed by a non-participating pharmacy are not covered***		
Prescription are subject to deductible - **after deductible**, the following copayments would apply:		
	Retail pharmacy 30-day supply	**Retail Pharmacy/Mail Order 31 - 90 day supply**
Tier 1:	$10	$20
Tier 2:	$30	$60
Tier 3:	$60	$120
Specialty Drugs**:	25%	N/A
Rx Out-of-Pocket Maximum *(Embedded)* :	Per Person: $500 Per Family: $1,000	
Preventive drugs - as required by the Affordable Care Act and defined in the Plan Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (Deductible waived)	
Limitations	Retail and Home Delivery: 90-day supply Specialty drugs and chemotherapy drugs: 30-day supply Smoking Cessation: Limited to 180-day supply per calendar year	
Mandatory generic and Step therapy	Applicable	
Specialty Drugs**	Specialty drugs are prescription legend drugs that we determine to be: (a) associated with a high level of clinical management and/or patient monitoring; (b) associated with special handling or distribution requirements; or (c) generally high cost.	

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