



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 844-672-8346. 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.dol.gov/ebsa/healthreform or call 844-672-8346 to request a copy.

Important Questions	Answers	Why This Matters:
<u>What is the overall deductible?</u>	<p>Tier 1 Network providers: \$1,750/individual or \$5,250/family</p> <p>Tier 2 Network providers: \$3,500/individual or \$10,500/family</p> <p>Out-of-network provider: \$7,000/individual or \$21,000/family</p>	<p>Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. The deductible is Embedded. 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.</p> <p>Deductible year runs 01/01 – 12/31</p>
<u>Are there services covered before you meet your deductible?</u>	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 care 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/ .
<u>Are there other deductibles for specific services?</u>	No.	You don't have to meet deductibles for specific services.
<u>What is the out-of-pocket limit for this plan?</u>	<p>Tier 1 Network providers: \$3,250/individual or \$6,500/family</p> <p>Tier 2 Network providers: \$6,500/individual or \$13,000/family</p> <p>Out-of-network provider: \$19,500/individual or \$39,000/family</p>	<p>The out-of-pocket limit is the most you could pay in a year for covered services. The out-of-pocket limit is Embedded. 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.</p>
<u>What is not included in the out-of-pocket limit?</u>	Premiums , balance billing charges, 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 <u>network provider</u>?	Yes. See RiverlandCommunityBenefits.com or call 844-672-8346 for a list of <u>network providers</u> .	This plan uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>).
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <u>specialist</u> you choose without a <u>referral</u> .



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
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copayment</u>	\$35 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .
	<u>Specialist</u> visit	\$20 <u>copayment</u>	\$35 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .
	<u>Preventive care/screening/immunization</u>	No charge		50% <u>coinsurance</u>	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if the services needed are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge		50% <u>coinsurance</u>	Labs in a clinic or independent lab setting are covered at no charge.
	Imaging (CT/PET scans, MRIs)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	May require <u>preauthorization</u> .
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <u>RochesterSchoolsBenefits.com</u>	Generic drugs	30-day supply Retail: \$12 <u>copayment</u> 90-day supply Mail Order: \$24 <u>copayment</u>			<u>Cost sharing</u> does not apply for <u>preventive Prescriptions</u> .
	Preferred Brand drugs	30-day supply Retail: \$50 <u>copayment</u> 90-day supply Mail Order: \$100 <u>copayment</u>			<u>Deductible</u> does not apply to <u>copayment</u> .
	Non-Preferred Brand drugs	30-day supply Retail: \$90 <u>copayment</u> 90-day supply Mail Order: \$180 <u>copayment</u>			Retail & Mail Order available up to a 90-day supply.
	<u>Specialty drugs</u>	30-day supply Mail: 20% <u>coinsurance</u> up to \$200			Retail & Mail Order available up to a 30-day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	May require <u>preauthorization</u> .
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need immediate medical attention	<u>Emergency room care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
	<u>Emergency medical transportation</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
	<u>Urgent care</u>	\$20 <u>copayment</u>	\$35 <u>copayment</u>		<u>Deductible</u> does not apply to <u>copayment</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.
	Physician/surgeon fees	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 <u>copayment</u>	\$35 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .
	Inpatient services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.
If you are pregnant	Office visits	No Charge		50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive</u> services.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	Depending on the type of services, a <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC.
	Childbirth/delivery facility services	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required. 60 visit limit per year.
	<u>Rehabilitation services</u>	\$20 <u>copayment</u>	\$35 <u>copayment</u>	50% <u>coinsurance</u>	<u>Deductible</u> does not apply to <u>copayment</u> .
	<u>Habilitation services</u>	\$20 <u>copayment</u>	\$35 <u>copayment</u>	50% <u>coinsurance</u>	Occupational Therapy: 30 visit limit per Deductible year Speech Therapy: 30 visit limit per Deductible year Physical Therapy: 30 visit limit per Deductible year
	<u>Skilled nursing care</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.
	<u>Durable medical equipment</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
	<u>Hospice services</u>	10% <u>coinsurance</u>	25% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> required.

* For more information about limitations and exceptions, see the plan or policy document at RiverlandCommunityBenefits.com.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 Network Provider (You will pay the least)	Tier 2 Network Provider	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	50% coinsurance	Limit of 1 routine exam per year.
	Children's glasses	Not Covered	Not Covered	Not Covered	None.
	Children's dental check-up	Not Covered	Not Covered	Not Covered	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](#).)

- Cosmetic surgery
- Weight loss programs
- Dental Care (Adult)
- Bariatric Surgery
- Acupuncture
- Long-term care
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Private Duty Nursing (inpatient only)
- Infertility Treatment (correction of physiological abnormalities)
- Emergency care when traveling outside the U.S.
- Chiropractic 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 those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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:

* For more information about limitations and exceptions, see the plan or policy document at RiverlandCommunityBenefits.com.

[Spanish (Español): Para obtener asistencia en Español, llame al 844-672-8346

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-672-8346

[Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 844-672-8346

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' 844-672-8346

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 plan's overall deductible	\$3,500
■ Specialist Copayment	\$35
■ Hospital (facility) Coinsurance	25%
■ Other Coinsurance	25%

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	\$12,731
In this example, Peg would pay:	
Cost Sharing	
Deductibles	\$3,500
Copayments	\$10
Coinurance	\$1,800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$5,370

Managing Joe's type 2 Diabetes

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

■ The plan's overall deductible	\$3,500
■ Specialist Copayment	\$35
■ Hospital (facility) Coinsurance	25%
■ Other Coinsurance	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*)

Total Example Cost	\$7,389
In this example, Joe would pay:	
Cost Sharing	
Deductibles	\$900
Copayments	\$1,100
Coinurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,020

Mia's Simple Fracture

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

■ The plan's overall deductible	\$3,500
■ Specialist Copayment	\$35
■ Hospital (facility) Coinsurance	25%
■ Other Coinsurance	25%

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	\$1,368
In this example, Mia would pay:	
Cost Sharing	
Deductibles	\$2,500
Copayments	\$100
Coinurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

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