



**Outline of Benefits – Option 1 - \$1,500/\$3,000 HDHP Plan**

**Medford Area Public Schools - Effective 1/1/2021**

PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay <sup>1</sup>
<b>Deductible: Non-embedded HDHP***</b>			
Single	\$1,500	\$2,000	\$3,000
Family	\$3,000	\$4,000	\$6,000
<b>Coinsurance</b>			
Coinsurance	0%	10%	30%
<b>Annual Out-of-Pocket Limit (includes deductible and coinsurance): Non-embedded HDHP****</b>			
Single	\$1,500	\$3,500	\$7,500
Family	\$3,000	\$7,000	\$15,000
<b>Covered Expenses (not including covered drugs and covered supplies dispensed by a pharmacy)</b>			
PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay <sup>1</sup>
Ambulance services**	Deductible	Signature Network Provider Deductible	Signature Network Provider Deductible
Behavioral health Therapy services Outpatient/Transitional services Inpatient services**	Deductible Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services – outpatient**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Emergency room – visit charge only	Deductible	Signature Network Provider Deductible	Signature Network Provider Deductible
Emergency room services	Deductible	Signature Network Provider Deductible	Signature Network Provider Deductible
Home care – limited to 40 visits per year	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	0%	0%
Injections - outpatient	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	0%	Deductible and Coinsurance
Office visits – visit charge only Primary Care Practitioner Specialist	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Preventive care services* (includes routine eye exams for children and adults)	0% (see separate preventive benefit schedule)	0% (see separate preventive benefit schedule)	Deductible and Coinsurance



**Outline of Benefits – Option 2 - \$5,500/\$11,000  
HDHP Plan  
Effective January 1, 2021**

PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay <sup>1</sup>
<b>Deductible: Embedded HDHP</b>			
Per Person	\$5,500	\$6,500	\$12,900
Per Family	\$11,000	\$13,000	\$25,800
<b>Coinsurance</b>			
Coinsurance	0%	10%	30%
<b>Annual Out-of-Pocket Limit (includes deductible and coinsurance): Embedded HDHP</b>			
Per Person	\$5,500	\$7,000	\$17,400
Per Family	\$11,000	\$14,000	\$34,800
<b>Covered Expenses (not including covered drugs and covered supplies dispensed by a pharmacy)</b>			
PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay <sup>1</sup>
Ambulance services**	Deductible	Signature Network Provider Deductible	Signature Network Provider Deductible
Behavioral health Therapy services	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient/Transitional services	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient services**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services – outpatient**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Emergency room – visit charge only	Deductible	Signature Network Provider Deductible	Signature Network Provider Deductible
Emergency room services	Deductible	Signature Network Provider Deductible	Signature Network Provider Deductible
Home care – limited to 40 visits per year	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	0%	0%
Injections - outpatient	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	0%	Deductible and Coinsurance
Office visits – visit charge only Primary Care Practitioner	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Specialist	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Preventive care services* (includes routine eye exams for children and adults)	0% (see separate preventive benefit schedule)	0% (see separate preventive benefit schedule)	Deductible and Coinsurance