Edgar School District

Health Insurance Election Form

Effective Date: July 1, 2023

Plan Specifics	Aspirus Health Plan			
Insurance Type				
	HDHP Non-Embedded HMO		HDHP Non-Embedded POS	
Provider Network:				
	Signature HMO		Freedom POS	
Deductible	**Single**	**Family**	**Single**	**Family**
In Network	$2,000	$4,000	$2,000	$4,000
Out of Network	Not Applicable		$4,000	$8,000
Co-Insurance				
In Network	100%		100%	
Out of Network	Not Applicable		80%	
HSA Contribution	**Single**	**Family**	**Single**	**Family**
District HSA	$1,000	$2,000	$1,000	$2,000
Maximum Out-of-Pocket (Ded/Coins)	**Single**	**Family**	**Single**	**Family**
In Network	$2,000	$4,000	$2,000	$4,000
Out of Network	Not Applicable		$5,500	$11,000
Max Out-of-Pocket (Ded/Coins/Copay)	**Single**	**Family**	**Single**	**Family**
In Network Medical	$2,500	$5,000	$2,500	$5,000
In Network Rx	Includes Rx Copays		Includes Rx Copays	
Out of Network	Not Applicable		Not Applicable	
Office Visits	**PCP**	**Specialist**	**PCP**	**Specialist**
In Network	100% After Deductible		100% After Deductible	
	100% After Deductible		100% After Deductible	
Out of Network	Not Covered		80% After Deductible	
Routine/Preventive Care				
In Network	Select Services Covered In Full		Select Services Covered In Full	
Out of Network	Not Covered		80% After Deductible	
Urgent Care				
In Network	100% After Deductible		100% After Deductible	
Out of Network	100% After Deductible		80% After Deductible	
Emergency Room				
	100% After Deductible		100% After Deductible	
Hospital Services				
In Network	100% After Deductible		100% After Deductible	
Out of Network	Not Covered		80% After Deductible	
Prescription Drugs	**Tier 1 / Tier 2 / Tier 3 / Tier 4**		**Tier 1 / Tier 2 / Tier 3 / Tier 4**	
In Network	Deductible, then $10/$30/$60/25%		Deductible, then $10/$30/$60/25%	
Monthly Premium	**Single**	**Family**	**Single**	**Family**
	$906.71	$1,920.16	$1,060.85	$2,246.59
Employee Monthly Contribution	$136.01	$288.02	$290.15	$614.45

My Election (Please check a box below)

Single ☐ ☐

Family ☐ ☐

Waiving Coverage ☐

Print Employee Name: _____

Employee Signature: _____ **Date:** _____