ASPIRUS HEALTH PLAN

School District of Pittsville
ASP10067
Outline of Benefits
Signature HMO HDHP
Effective July 1, 2023

Pittsville Panthers

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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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% to $250	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.	

This is a brief summary of benefits created from a sales quote presentation. Finalized benefits will take precedence over any benefit information presented in this outline. See the Master Policy for complete details.

*Includes preventive screenings as required by the United States Preventive Services Task Force (USPSTF)

** Some services may require prior authorization. Please go to our website www.aspirushealthplan.com for further

ASPIRUS HEALTH PLAN

School District of Pittsville
ASP10067
Outline of Benefits
Freedom 3-Tier Choice POS HDHP
Effective July 1, 2023

Pittsville Panthers

Benefit Accumulator — **Plan Year (July 1 - June 30)**

PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Deductible - Non-Embedded - *one person, in a family, can satisfy the family deductible amounts noted below* *(Note: Signature Network and Freedom Network deductible amounts credit toward one another. Non-participating providers deductibles are separate.)*			
Single	$1,500	$2,000	$2,500
Family	$3,000	$4,000	$5,000
Coinsurance			
Coinsurance	0%	10%	30%
Annual Out-of-Pocket Limit (includes deductible and medical coinsurance) - Non-Embedded - *one person, in a family, can satisfy the family out-of-pocket amounts noted below* *(Note: Signature Network and Freedom Network out-of-pocket amounts credit toward each other. Non-participating provider amounts are separate.)*			
Single	$1,500	$2,500	$3,000
Family	$3,000	$5,000	$6,000

Amounts Credit

PROVISION/BENEFIT	SIGNATURE PROVIDERS What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Ambulance services**	Deductible and Coinsurance	Signature Network Provider Deductible & Coinsurance	Signature Network Provider Deductible & Coinsurance
Behavioral health			
Therapy services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Outpatient/Transitional Services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services**	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Emergency room - visit charge only	Deductible and Coinsurance	Signature Network Provider Deductible & Coinsurance	Signature Network Provider Deductible & Coinsurance
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Home care - limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	0%	Deductible and Coinsurance
Injections - outpatient	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	0%	Deductible and Coinsurance
Office visits - visit charge only			
Primary Care Practitioner	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Specialist	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Preventive Care Services* (includes routine eye exams for children and adults)	0%	0%	Deductible and Coinsurance
Surgical services	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth visits (through MDLIVE) General Counseling Psychiatry Dermatology	0%	Not covered	Not Covered
Therapy visits (physical/speech/occupational Office setting Home or outpatient hospital setting	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
Transplant Services**	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance
All other health care services - unless otherwise stated in your plan	Deductible and Coinsurance	Deductible and Coinsurance	Deductible and Coinsurance

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** Some services may require prior authorization. Please go to our website www.aspirushealthplan.com for further information or call Aspirus Health Plan at 866.631.5404.

***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.**