ASPIRUS HEALTH PLAN

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[1]
Deductible: Non-embedded HDHP* **			
Single	$1,500	$2,000	$3,000
Family	$3,000	$4,000	$6,000
Coinsurance			
Coinsurance	0%	10%	30%
Annual Out-of-Pocket Limit (includes deductible and coinsurance): Non-embedded HDHP** **			
Single	$1,500	$3,500	$7,500
Family	$3,000	$7,000	$15,000

Amounts Credit

Amounts Credit

Covered Expenses (not including covered drugs and covered supplies dispenses by a pharmacy)

PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay[1]
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

PROVISION/BENEFIT	SIGNATURE NETWORK What you pay	FREEDOM NETWORK What you pay	NON-PARTICIPATING PROVIDERS What you pay[1]
Surgical services	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Telehealth visits (using our approved participating telehealth provider)	Deductible	Not Covered	Not Covered
Therapy visits (physical/ speech/occupational) Office setting Home or outpatient hospital setting	Deductible Deductible	Deductible and Coinsurance Deductible and Coinsurance	Deductible and Coinsurance Deductible and Coinsurance
Transplant services**	Deductible	Not Covered	Not Covered
All other health care services – unless otherwise stated in your plan	Deductible	Deductible and Coinsurance	Deductible and Coinsurance
Covered Drugs and Covered Supplies			
Prescription drugs and certain diabetic supplies	Participating Provider Deductible and Coinsurance ***(Drugs and covered supplies dispensed by a non-participating pharmacy are not covered.)***		
Preventive drugs – as required by the Affordable Care Act and defined in the policy Also includes additional preventive drugs at no cost to you (refer to $0 Drug List for details).	0% (Deductible waived)		
Limitations	Retail: 90-day supply Home Delivery: 90-day supply Specialty drugs and Chemotherapy drugs: 30-day supply Smoking Cessation – Limited to 180-day supply		
Mandatory generic & Step therapy	Applicable – If a brand drug is dispensed when a generic equivalent is available, you are responsible for the difference in cost between the brand and generic, unless your physician specifically instructs to "dispense as written." This difference is not applied to the out-of-pocket limits noted above.		
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 summary of benefits created from a sales quote presentation. Finalized benefits will take precedence over any benefit information presented in this outline.

* 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 aspirushealthplan.com/group for further information.
*** If enrolled in family policy, coinsurance does not begin until family deductible is met.
**** If enrolled in family policy, benefits are not paid at 100% until family out-of-pocket limit is met.

[1]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 our 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.*