Mosinee School District
Outline of Benefits
Signature HMO HDHP $2,000
Effective July 1, 2023

PROVISION/BENEFIT	PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay
Deductible - Non-Embedded HDHP		
Single	$2,000	Not Applicable
Family	$4,000	Not Applicable
Coinsurance		
Coinsurance	20%	Not Applicable
Annual Out-of-Pocket Limit (includes deductible, coinsurance, and copayments) - Non-Embedded HDHP		
Single	$4,000	Not Applicable
Family	$8,000	Not Applicable
Covered Expenses (not including drugs and covered supplies dispenses by a pharmacy)		
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, after deductible is satisfied then services are subject to $200 copayment and coinsurance	Participating provider deductible, after deductible is satisfied then services are subject to $200 copayment and coinsurance
Emergency room services	Deductible and Coinsurance	Participating provider deductible and Coinsurance
Urgent Care	Deductible, after deductible is satisfied then services are subject to $30 copayment	Participating provider deductible, after deductible is satisfied then services are subject to $30 copayment
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, after deductible is satisfied then services are subject to $30 copayment Deductible, after deductible is satisfied then services are subject to $60 copayment	Not Covered

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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	The following fees are subject to deductible and coinsurance: $50 $90 $250 $59	Not Covered
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)***	Dispensed by a retail pharmacy: Tier 1: Deductible, after deductible is satisfied then $10 copayment Tier 2: Deductible, after deductible is met then $30 copayment Tier 3: Deductible, after deductible is met then $60 copayment Specialty: Deductible, after deductible is met then 25% coinsurance	
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 information or call Aspirus Health Plan at 866.631.5404.