ASPIRUS HEALTH PLAN

Wausau School District

Outline of Benefits – Signature Network Traditional Plan

Effective: January 1, 2022

PROVISION/BENEFIT	SIGNATURE NETWORK PARTICIPATING PROVIDERS What you pay	NON-PARTICIPATING PROVIDERS What you pay***
Deductible (Note: Out-of-Network deductibles will credit toward in-network deductible, but not vice versa)		
Per Covered Person	$500	$500
Per Family	$1,000	$1,000
Coinsurance		
Coinsurance	10%	30%
Annual Out-of-Pocket Limit (includes deductible and coinsurance) – (Note: Out-of-Network will credit toward in-network, but not vice versa)		
Per Covered Person	$2,000	$3,000
Per Family	$4,000	$6,000
Maximum Annual Out-of-Pocket Limit (includes deductible, coinsurance & all copayments)		
Per Covered Person	$7,350	$7,350
Per Family	$14,700	$14,700
Covered Expenses (not including covered drugs and covered supplies dispenses by a pharmacy)		
PROVISION/BENEFIT	**SIGNATURE NETWORK 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**	 0% 0% Deductible	 10% Coinsurance 10% Coinsurance Deductible
Chiropractic office visit/manipulations	Deductible and Coinsurance	Deductible and Coinsurance
Contraceptives	0%	Deductible and Coinsurance
Diagnostic x-ray and laboratory services – outpatient**	Deductible and Coinsurance	Deductible and Coinsurance
Durable medical equipment**	Deductible and Coinsurance	Deductible and Coinsurance
Emergency Medical Care	Deductible, Coinsurance, or applicable Copayment	Participating Provider Deductible, Coinsurance, or applicable Copayment
Emergency room – visit charge only	$100 Copayment, then 0%	$100 Copayment, then 0%
Emergency room services	Deductible and Coinsurance	Participating Provider Deductible and Coinsurance
Home care – limited to 40 visits per year	Deductible and Coinsurance	Deductible and Coinsurance
Hospital inpatient services**	Deductible and Coinsurance	Deductible and Coinsurance
Immunizations	0%	Deductible and Coinsurance
Injections - outpatient	Deductible and Coinsurance	Deductible and Coinsurance
Kidney disease treatment	Deductible and Coinsurance	Deductible and Coinsurance
Maternity services	Deductible and Coinsurance	Deductible and Coinsurance
Medical supplies	Deductible and Coinsurance	Deductible and Coinsurance
Nutritional counseling	0%	Deductible and Coinsurance

<table>
<tr><th>PROVISION/BENEFIT</th><th>SIGNATURE NETWORK
PARTICIPATING PROVIDERS
What you pay</th><th>NON-PARTICIPATING PROVIDERS
What you pay***</th></tr>
<tr><td>Office visits – visit charge only
Primary Care Practitioner
Specialist</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td></tr>
<tr><td>Preventive care services* (includes routine eye exams for children and adults)</td><td>0%</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Surgical services</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Therapy visits (physical/ speech/occupational)
Office setting
Home or outpatient hospital setting</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td><td>
Deductible and Coinsurance
Deductible and Coinsurance</td></tr>
<tr><td>Transplant services**</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance</td></tr>
<tr><td>Urgent Care – visit charge only</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance unless Emergency Medical Care (see benefit above)</td></tr>
<tr><td>Urgent Care Services</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance unless Emergency Medical Care (see benefit above)</td></tr>
<tr><td>All other health care services – unless otherwise stated in your plan</td><td>Deductible and Coinsurance</td><td>Deductible and Coinsurance</td></tr>
<tr><td colspan="3">Covered Drugs and Covered Supplies</td></tr>
<tr><td>Prescription drugs</td><td colspan="2"><table><tr><td></td><td>Retail & Home Delivery</td></tr><tr><td></td><td>90-day supply</td></tr><tr><td>Tier 1:</td><td>$5 Copayment</td></tr><tr><td>Tier 2:</td><td>$20 Copayment</td></tr><tr><td>Tier 3:</td><td>$40 Copayment</td></tr><tr><td>Specialty Medications**</td><td>25% to $100 (limited to 30-day supply)</td></tr><tr><td>Diabetic Supplies</td><td>$0</td></tr></table>Oral chemotherapy drugs are limited to $100 copayment for a 30-day supply
Smoking cessation medications limited to 180 days per calendar year</td></tr>
<tr><td>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).</td><td colspan="2">0% (copayment waived)</td></tr>
<tr><td>Limitations</td><td colspan="2">Retail: 30 or 90-day supply Home Delivery: 90-day supply
Specialty drugs and Chemotherapy drugs: 30-day supply
Smoking Cessation – Limited to 180-day supply</td></tr>
<tr><td>Mandatory generic & Step therapy</td><td colspan="2">Applicable – If a brand drug is dispensed when a generic equivalent is available, you are responsible for the brand copayment plus 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.</td></tr>
<tr><td>Specialty drugs**</td><td colspan="2">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.</td></tr>
</table>

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.

* 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.

***Out-of-network services are subject to usual, customary, and reasonable (“UCR”) amounts. The UCR amount 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 the UCR amount (often referred to as “balance billing”). *These amounts do not apply to the overall deductible and out-of-pocket maximums noted above*.

Note: Balance billing will not occur if emergency room services are obtained out-of-network, or when you obtain an approved referral, from Aspirus Health Plan, to utilize an out-of-network provider for services.