

HMO Silver 7150

Coverage Period: 1/1/2021 - 12/31/2021

Coverage for: Individual/Family | Plan Type: HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health <u>plan</u>. The SBC shows you how you and the <u>plan</u> would share the cost for covered health care services. NOTE: Information about the cost of this <u>plan</u> (called the <u>premium</u>) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit aspirushealthplan.com or call 866-631-4611. For general definitions of common terms, such as <u>allowed amount</u>, <u>balance billing</u>, <u>coinsurance</u>, <u>copayment</u>, <u>deductible</u>, <u>provider</u>, or other <u>underlined</u> terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary /or call 866-631-4611 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For participating <u>providers</u> : \$7,150 / Covered Person or \$14,300 / Family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> services, office visits and prescription drugs, other than <u>specialty drugs</u> , purchased from a pharmacy are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$750 / Covered Person or \$1,500 / Family for specialty drugs. There are no other specific deductibles.	You must pay all of the costs for these services up to the specific <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For participating <u>providers</u> : \$7,150 / Covered Person or \$14,300 / Family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit?</u>	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a <u>network provider</u> ?	Yes. See https://p1.aspirushealthplan.com/find-a-doctor/ or call 866-631-4611 for a list of network providers.	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider before you get services</u>.</u>
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This plan will pay some or all of the costs to see a non-participating or tertiary specialist for covered services, but only if you have a referral before you see the specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

		What You	Will Pay	
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Primary care visit to treat an injury or illness	\$35 <u>copayment</u> / office visit and 0% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the office visit charge	Not covered	\$0 copayment / telehealth visit charge with our approved telehealth provider \$10 copayment / office visit charge for a convenient care clinic visit \$35 copayment / visit for chiropractor
If you visit a health care <u>provider's</u> office or clinic	<u>Specialist</u> visit	\$70 copayment / office visit and 0% coinsurance for other outpatient services; deductible does not apply to the office visit charge	Not covered	None
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% coinsurance	Not covered	Certain genetic tests and high-technology imaging may require prior authorization.
ii you nave a test	Imaging (CT/PET scans, MRIs)	0% coinsurance	Not covered	Benefits may not be payable if you do not obtain prior authorization.
If you need drugs to treat your illness or condition	Tier 1 drugs	Retail: \$20 copayment / prescription (30-day supply) & 2.5 times the retail copayment / prescription (90-day supply) for retail and home delivery	Not covered	Preferred generic drugs are no charge. The <u>deductible</u> does not apply to generic and brand name drugs which are not <u>specialty</u> <u>drugs</u> .

		What You	Will Pay	
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
More information about prescription drug	Tier 2 drugs	Retail: \$40 copayment / prescription (30-day supply) & 2.5 times the retail copayment / prescription (90-day supply) for retail and home delivery	Not covered	Covers up to a 90-day supply. If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which does not count toward your out-of-pocket limit. Drugs provided by an entity other
coverage is available at https://www.aspirushealt hplan.com/group-individual/Aspirus_Drug_Formulary/AspirusDrugFormulary2021.pdf	Tier 3 drugs	Retail: \$70 copayment / prescription (30-day supply) & 2.5 times the retail copayment / prescription (90-day supply) for retail and home delivery	Not covered	than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Specialty drugs are subject to a separate deductible amount and are always limited to a 30-day supply. Specialty drugs require prior
	Specialty drugs	40% <u>coinsurance</u> / prescription (retail & home delivery)	Not covered	authorization. Benefits may not be payable if you do not obtain prior authorization.
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	Not covered	None
surgery	Physician/surgeon fees	0% coinsurance	Not covered	None
If you need immediate	Emergency room care	\$450 copayment / emergency room charge and 0% coinsurance for other emergency room services; deductible does not apply to the emergency room charge	\$450 copayment / emergency room charge and 0% coinsurance for other emergency room services; deductible does not apply to the emergency room charge	
medical attention	Emergency medical transportation	0% coinsurance	0% coinsurance	
	<u>Urgent care</u>	\$35 <u>copayment</u> / urgent office visit and 0% <u>coinsurance</u> for other urgent care services; <u>deductible</u> does not apply	\$35 <u>copayment</u> / urgent office visit and 0% <u>coinsurance</u> for other urgent care services; <u>deductible</u> does not apply	Urgent care professional charges may be subject to the \$70 specialist office visit copayment depending on the specialty of the physician providing treatment.

			What You	Will Pay	
Commo Medical E		Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have a h	ospital	Facility fee (e.g., hospital room)	0% coinsurance	Not covered	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
stay		Physician/surgeon fees	0% coinsurance	Not covered	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need me health, behavion health, or substabuse services	oral stance	Outpatient services	\$35 <u>copayment</u> / therapy office visit and 0% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the therapy office visit charge	Not covered	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
		Inpatient services	0% coinsurance	Not covered	
If you are preg	nant	Office visits	\$35 <u>copayment</u> / office visit and 0% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the office visit charge	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital
		Childbirth/delivery professional services	0%_coinsurance	Not covered	stays require prior authorization. Benefits may not be payable if you do not obtain prior
		Childbirth/delivery facility services	0% coinsurance	Not covered	authorization.
		Home health care	0% coinsurance	Not covered	Coverage is limited to 60 visits/year
If you need hel recovering or I other special h needs	have	Rehabilitation services	\$35 <u>copayment</u> / therapy office visit and 0% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the therapy office visit charge	Not covered	Rehabilitation services: Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy. Habilitation services:

		What You	Will Pay	
Common Medical Event	Services You May Need	Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Habilitation services	\$35 <u>copayment</u> / therapy office visit and 0% <u>coinsurance</u> for other outpatient services; <u>deductible</u> does not apply to the therapy office visit charge	Not covered	Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; and 20 visits/year for speech therapy.
	Skilled nursing care	0% coinsurance	Not covered	Coverage is limited to 30 days per confinement in a skilled nursing facility. Non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Durable medical equipment	0% <u>coinsurance</u>	Not covered	Coverage is limited to a single purchase of a type of durable medical equipment every three years. Prior authorization required for: • All CPAP purchases and rentals • Purchases over \$1,000 • All other rentals as stated on our website Benefits may not be payable if you do not obtain prior authorization.
	Hospice services	0% coinsurance	Not covered	Hospice services require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
f your obild poods	Children's eye exam	No charge	Not covered	Coverage limited to one exam/year.
f your child needs lental or eye care	Children's glasses	No charge	Not covered	Coverage limited to one pair of glasses/year.
	Children's dental check-up	Not covered	Not covered	No coverage for dental check-ups.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Acupuncture
- Bariatric Surgery
- Cosmetic Surgery

- Dental Care
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Chiropractic Care

Hearing Aids

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: for the Wisconsin Office of the Commissioner of Insurance at 1-800-236-8517; or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. For more information about your rights, this notice, or assistance, contact: Aspirus at 866-631-4611. You may also contact your state insurance department at 1-800-236-8517.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Not Applicable.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 866-631-4611.

Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu 866-631-4611.

Traditional Chinese (傳統中文): 有關中文協助,請致電 866-631-4611.

German (Deutsch): Für Hilfe in deutscher Sprache rufen 866-631-4611.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$7,150
■ Specialist copayment	\$70
■ Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost

In this example, Peg would pay	<i>y</i> :
Cost Sharing	9
Deductibles	\$7,090
Copayments	\$60
Coinsurance	\$0
What isn't cove	red
Limits or exclusions	\$30
The total Peg would pay is	\$7,180

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$7,150
Specialist copayment	\$70
Hospital (facility) coinsurance	0%
Other coinsurance	0%

This EXAMPLE event includes services like:

Primary care physician office visits (including disease education)

Diagnostic tests (blood work)

Prescription drugs

\$12,700

Durable medical equipment (glucose meter)

Total Example Cost	\$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$310
Copayments	\$1,530
Coinsurance	\$0
What isn't covere	d
Limits or exclusions	\$0
The total Joe would pay is	\$1,840

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$7,150
Specialist copayment	\$70
■ Hospital (facility) coinsurance	0%
■ Other coinsurance	0%

This EXAMPLE event includes services like:

Emergency room care (including medical supplies)

Diagnostic test (x-ray)

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,860
Copayments	\$650
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,510



Non-Discrimination and Language Access Policy

Aspirus Health Plan, Inc. (Aspirus Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, call us at the phone number on the attached correspondence, your ID card, or the number listed on **AspirusHealthPlan.com**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Aspirus Health Plan

Attn: Nondiscrimination Grievance Coordinator

PO Box 1062

Minneapolis, MN 55440

Emails: G&A@AspirusHealthPlan.com

You can file a grievance in person, by mail, or by email. If you need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; or by phone at 1–800–368–1019, TTY: 1–800–537–7697. Complaint forms are available at hhs. gov/ocr/office/file/index.html. Albanian VINI RE: Nëse flisni shqip, ju ofrohen shërbime ndihme gjuhësore falas. Na telefononi në numrin e telefonit që gjendet në korrespondencën e bashkëngjitur, në pjesën e përparme të kartës suaj ID ose në numrin e renditur në adresën www.aspirushealthplan.com (TTY: 711). Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بنا على رقم الهاتف الموجود بالرسالة المرفقة أو بالجهة الأمامية لبطاقة تعريف الهوية الخاصة بك أو على الرقم المدرج بالمواقع الإلكترونية التالية Arabic تعريف الهوية الخاصة بك أو على الرقم المدرج بالمواقع الإلكترونية التالية

French À NOTER : Si vous parlez le français, des services d'assistance linguistique gratuits sont à votre disposition.

Appelez-nous au numéro de téléphone indiqué sur le courrier joint, au recto de votre carte d'identité ou au numéro indiqué sur le site Internet www.aspirushealthplan.com (ATS: 711).

German HINWEIS: Wenn Sie Deutsch sprechen, stehen für Sie kostenlos Sprachassistenzdienste zur Verfügung. Rufen Sie uns an. Sie finden die Telefonnummer auf dem beigefügten Schreiben, auf der Vorderseite Ihrer ID-Karte oder unter www.aspirushealthplan.com (TTY: 711).

आपकेहुपचान पत्स (आईडी कार्ड) केसामने केपृष्ठ पर दिए गए फ़ोन नंबर या <u>www.aspirushealthplan.com</u> पर दिए गए नंबर पर Hindi ध्यान दें: अगर आप हन्द्री बोलते हंतो आपकेलिए भाषा हसायता सेवाएँ ि शुल्क उपलब्ध हं हमें संलग्न पत्राचार पता,

Hmong TSHWJ XEEB: Yog hais tias koj hais lus Hmoob, peb muaj cov kev pab cuam hais ua koj hom lus pub rau koj yam tsis xam tus nqi hlo li. Hu rau peb tus nab npawb xov tooj nyob rau ntawm daim ntawv, sab hauv ntej ntawm koj daim d lossis nab npawb xov tooj nyob rau hauv www.aspirushealthplan.com (TTY: 711).

Korean 주목해 주세요: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 첨부된 서신, ID 카드 앞면 또는 www.aspirushealthplan.com에 나와 있는 전화번호로 연락해 주십시오(TTY: 711). Polish UWAGA: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany w załączonej korespondencji, z przodu karty identyfikacyjnej lub numer podany na stronie <u>www.aspirushealthplan.com</u>

Russian ВНИМАНИЕ! Если Вы говорите по-русски, Вы можете бесплатно воспользоваться услугами переводчика. Позвоните по любому номеру, указанному: в прикрепленном письме, на лицевой стороне Вашей идентификационной карты или на сайтах www.aspirushealthplan.com (телетайп: 711). Spanish ATENCIÓN: Si habla español, los servicios de asistencia de idioma están disponibles para usted, sin ningún costo para usted. Llámenos al número de teléfono que se encuentra en la correspondencia adjunta, en la parte de adelante de su tarjeta de identificación o en el número indicado en www.aspirushealthplan.com (TTY: 711).

Tagalog BIGYANG-PANSIN: Kung Tagalog ang ginagamit mong wika, may mga serbisyong tulong sa wika na makukuha mo nang walang babayaran. Tawagan kami sa numero ng telepono na nasa nakalakip na sulat, nasa harapang bahagi ng iyong id card o nakalistang numero sa www.aspirushealthplan.com (TTY: 711). Traditional Chinese 注意:如果您使用繁體中文,您可以免费獲得語言援助服務。請撥打隨附之通訊上、ID 卡正 面或以下網址:www.aspirushealthplan.com列出的電話號碼與我們聯絡(TTY: 711)。 Vietnamese CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Hãy gọi cho chúng tôi theo số điện thoại có trên thư từ đính kèm, mặt trước thẻ id của quý vị hoặc số điện thoại được niêm yết trên www.aspirushealthplan.com (TTY: 711).

Pennsylvania Dutch GEB ACHT: Wann du Deitsch schwetzscht, du kannscht Schprooch Services griege, mitaus Koschd. Ruf uns mit der Nummer uff die attached correspondence, die vonne Seide vun dei ID Kaarde odder die Nummer uff www.aspirushealthplan.com(TTY: 711). Lao ສຳລັບທ່ານທີ່ສົນໃຈ. ຖ້າທ່ານເວົ້າພາສາລາວ, ມີບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ຄິດຄ່າໃຊ້ຈ່າຍ ສຳລັບທ່ານ. ທ່ານສາມາດໂທ ຫາພວກເຮົາໄດ້^ເທີ່ໝາຍເລກຢູ່ເທິງຈົດໝາຍຕິດຕໍ່ທີ່ຕິດຄັດມາ, ດ້ານໜ້າບັດປະຈຳຕົວຂອງທ່ານ ຫຼື ໝາຍເລກທີ່ລະບຸໄ*ວ*ໃນ

www.aspirushealthplan.com (TTY: 711)