

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
HMO Silver 4000



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) 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, [insert contact information]. For definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 866-631-5404 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-network: \$4,000/\$8,000 (individual/family-\$4,000 per family member). Out-of-network: No coverage.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan , each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	Yes. \$750/\$1,500 (individual/family) for specialty drug . There are no other specific deductibles .	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-network: \$8,150/\$16,300 (individual/family-\$8,150 per family member). Out-of-network: No coverage.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	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 network provider?	Yes. See https://p1.aspirushealthplan.com/find-a-doctor or call 866-631-5404 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can choose an in-network specialist without a referral .

 All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$45 copayment /visit and 10% coinsurance for other outpatient services; deductible does not apply to the office visit charge.	Not covered	\$0 copayment /visit for telehealth visit charge with our approved telehealth provider. \$10 copayment /visit for convenience care clinic visit. \$45 copayment /visit for chiropractor.
	Specialist visit	\$90 copayment /visit and 10% coinsurance for other outpatient services; deductible does not apply to the office visit charge.	Not covered	None
	Preventive care/screening/immunization	No charge (deductible does not apply)	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. No charge for immunizations provided by a non-participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Certain genetic tests and high-technology imaging require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aspirushealthplan.com/group-individual/drug-formularies/	Tier 1 drugs	Retail: \$20 copayment /prescription (30-day supply) Retail and mail: 2.5 times the retail copay/prescription (90-day supply)	Not covered	Preventive generic drugs are no charge. Covers up to a 90-day supply retail/mail order. If a brand drug 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.
	Tier 2 drugs	Retail: \$40 copayment /prescription (30-day supply) Retail and mail: 2.5 times the retail copay/prescription (90-day supply)	Not covered	Covers up to a 90-day supply retail/mail order. If a brand drug 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.
	Tier 3 drugs	Retail: \$70 copayment /prescription (30-day supply) Retail and mail: 2.5 times the retail copay/prescription (90-day supply)	Not covered	Covers up to a 90-day supply retail/mail order. If a brand drug 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.
	Specialty drugs	Retail and mail: 40% coinsurance /prescription (deductible does not apply)	Not covered	Specialty drugs are subject to a separate deductible and are limited to a 30-day supply. Specialty drugs and drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization.

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		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	None
	Physician/surgeon fees	10% coinsurance	Not covered	None
If you need immediate medical attention	Emergency room services	\$500 copayment /ER visit and 10% coinsurance for other emergency room services; deductible does not apply to the emergency room charge.	\$500 copayment /ER visit and 10% coinsurance for other emergency room services; deductible does not apply to the emergency room charge.	None
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	\$45 copayment /urgent office visit and 10% coinsurance for other urgent care services; deductible does not apply to the urgent office visit charge.	\$45 copayment /urgent office visit and 10% coinsurance for other urgent care services; deductible does not apply to the urgent office visit charge.	Urgent care professional charges may be subject to the \$90 specialist office visit copayment depending on the specialty of the physician providing treatment.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	10% 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 mental health, behavioral health, or substance abuse services	Outpatient services	\$45 copayment /visit and 10% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge.	Not covered	None
	Inpatient services	10% coinsurance	Not covered	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you are pregnant	Office visits	\$45 copayment /visit and 10% coinsurance for other outpatient services; deductible 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, copayment , coinsurance , deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery professional services	10% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment , coinsurance , deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery facility services	10% coinsurance	Not covered	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment , coinsurance , deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				prior authorization. Benefits may not be payable if you do not obtain prior authorization.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	Coverage is limited to 60 visits/year.
	Rehabilitation services	\$45 copayment /visit and 10% coinsurance for other outpatient services; deductible 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; 20 visits/year for speech therapy.
	Habilitation services	\$45 copayment /visit and 10% coinsurance for other outpatient services; deductible 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; 20 visits/year for speech therapy.
	Skilled nursing care	10% 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	10% coinsurance	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 states on our website Benefits may not be payable if you do not obtain prior authorization.
	Hospice service	10% coinsurance	Not covered	Hospice service s require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If your child needs dental or eye care	Children's eye exam	No charge (deductible does not apply)	Not covered	Coverage limited to one exam/year.
	Children's glasses	No charge (deductible does not apply)	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 the 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 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.)

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| • Chiropractic care | • Hearing aids | • Routine eye care (Adult) |
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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 [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Aspirus Health Plan at 1-866-631-5404. 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 the Minimum Value Standards? Yes

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 866-631-5404.

Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu 866-631-5404.

Traditional Chinese (傳統中文): 有關中文協助,請致電 866-631-5404.

German (Deutsch): Für Hilfe in deutscher Sprache rufen 866-631-5404.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost-sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). 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 plan's overall deductible	\$4,000
■ Specialist copay	\$90
■ Hospital (facility) coinsurance	20%
■ Other coinsurance	20%

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	\$12,700
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$4,000
Copayments	\$10
Coinsurance	\$1500
What isn't covered	
Limits or Exclusions	\$60
The total Peg would pay is	\$5,570

Managing Joe's Type 2 Diabetes

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

■ The plan's overall deductible	\$4,000
■ Specialist copay	\$90
■ Hospital (facility) coinsurance	20%
■ Other copay	\$20

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (including disease education)
[Diagnostic tests](#) (blood work)
[Prescription drugs](#)
[Durable Medical Equipment \(glucose meter\)](#)

Total Example Cost	\$5,600
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$800
Copayments	\$900
Coinsurance	\$0
What isn't covered	
Limits or Exclusions	\$30
The total Joe would pay is	\$1,730

Mia's Simple Fracture

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

■ The plan's overall deductible	\$4,000
■ Specialist copay	\$90
■ Hospital (facility) copay	\$500
■ Other coinsurance	20%

This EXAMPLE event includes services like:

[Emergency room care](#) (including medical supplies)
[Diagnostic tests](#) (x-ray)
[Durable medical equipment](#) (crutches)
[Rehabilitation services](#) (physical therapy)

Total Example Cost	\$2,800
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1300
Copayments	\$800
Coinsurance	\$0
What isn't covered	
Limits or Exclusions	\$0
The total Mia would pay is	\$2,100

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination and Language Access Policy

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

We will:

- Provide 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)
- Provide 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, contact us at the phone number shown on the inside cover of this COC, your id card, or aspirushealthplan.com.

If you believe that we have 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:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1. 866.631.5404 (TTY: 1.866.631.8597)
Fax: 763.847.4010
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or 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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Assistance Services

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.866.631.5404 (ATS : 1.866.631.8597).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 1.866.631.8597).

Hindi: यान द : य द आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल ध ह ।1.866.631.5404 (TTY: 1.866.631.8597) पर कॉल कर ।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1.866.631.5404 (TTY: 1.866.631.8597).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1.866.631.5404 (TTY: 1.866.631.8597)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1.866.631.5404 (TTY: 1.866.631.8597).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1.866.631.5404 (телетайп: 1.866.631.8597).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 1.866.631.8597).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1.866.631.5404 (TTY: 1.866.631.8597).

Traditional Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1.866.631.5404 (TTY：1.866.631.8597)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1.866.631.5404 (TTY: 1.866.631.8597).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannst du mitaus Koschte ebergericke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1.866.631.5404 (TTY: 1.866.631.8597).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຄວນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 1.866.631.8597).