2024 Small Group HMO Plan Summary

Health Maintenance Organization (HMO) HSA-Qualified High-Deductible Health Plans

		You Pay (In-Network Services)[1]										
Metal Tier	**SBC Lookup**	**Individual Deductible**	**Coinsurance**	**Individual Annual Max Out of Pocket**	**Emergency Room**	**MDLive Visit**	**Retail Clinic Visit**	**PCP Visit**	**Specialty Visit**	**Outpatient Lab/X-ray**	**Outpatient Surgery**	**Hospital**
Gold[2]	86584WI0040012-00	$2,800	0%	$2,800	No charge after deductible							
Gold	86584WI0040021-00	$3,150	0%	$3,150	No charge after deductible							
Silver[3]	86584WI0040013-00	$2,400	30%	$7,550	30% after deductible							
Silver	86584WI0040015-00	$3,250	20%	$7,450	20% after deductible							
Silver	86584WI0040022-00	$4,300	20%	$5,300	20% after deductible							
Silver	86584WI0040016-00	$5,200	0%	$5,200	No charge after deductible							
Bronze	86584WI0040017-00	$6,200	30%	$7,200	30% after deductible							
Bronze	86584WI0040018-00	$7,200	0%	$7,200	No charge after deductible							
Bronze	86584WI0040024-00	$8,050	0%	$8,050	No charge after deductible							

Prescription Drugs: Preventive: $0; All others: deductible and coinsurance
Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

[1]Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

[2]Non-Embedded Deductible and Out-of-Pocket Limit: This plan features a non-embedded deductible and out-of-pocket limit. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. If an employee has family coverage, the family out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family out-of-pocket limit. Deductibles and out-of-pocket maximums apply annually.

[3]Non-Embedded Deductible and Embedded Out-of-Pocket Limit: This plan features a non-embedded deductible. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. This plan features an embedded out-of-pocket limit. The individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

2024 Small Group POS Plan Summary

Point-of-Service (POS) Plans

		You Pay (At Participating Providers[1])												
Metal Tier	SBC Lookup	Individual Deductible[1]		Coinsurance		Individual Annual Max Out of Pocket[1]		Emergency Room	MDLive Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Outpatient Lab/X-ray	Outpatient Surgery	Hospital
		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network								
Gold	86584WI0030002-00	$1,150	$2,300	20%	50%	$6,800	$12,300	D/C	$0	$10	$35	$70	20% after deductible		
Gold	86584WI0030006-00	$2,600	$5,200	20%	50%	$4,600	$15,200	D/C	$0	$10	$35	$70	20% after deductible		
Silver	86584WI0030009-00	$3,700	$7,400	20%	50%	$8,650	$17,400	D/C	$0	$10	$45	$90	20% after deductible		
Silver	86584WI0030010-00	$4,500	$9,000	10%	40%	$9,050	$17,000	D/C	$0	$10	$45	$90	10% after deductible		

Gold Prescription Drugs: Preventive: $0; Tier 1: $15; Tier 2: $30; Tier 3: $60; Tier 4: 30% coinsurance

Silver Prescription Drugs: Preventive: $0; Tier 1: $25; Tier 2: $50; Tier 3: $80; Tier 4: $750 deductible, then 40% coinsurance

Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

[1]Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

2024 Small Group POS Plan Summary

Point-of-Service (POS) HSA-Qualified High-Deductible Health Plans

ASPIRUS HEALTH PLAN

Metal Tier	SBC Lookup	You Pay (At Participating Providers[1])													
		Individual Deductible[1]		Coinsurance		Individual Annual Max Out of Pocket[1]		Emergency Room	Telehealth Visit	Retail Clinic Visit	PCP Visit	Specialty Visit	Outpatient Lab/X-ray	Outpatient Surgery	Hospital
		In Network	Out of Network	In Network	Out of Network	In Network	Out of Network								
Gold[2]	86584WI0030012-00	$2,800	$5,600	0%	30%	$2,800	$11,600	D/C	D/C	D/C	D/C	D/C	No charge after deductible		
Silver	86584WI0030015-00	$3,250	$6,500	20%	50%	$7,450	$16,500	D/C	D/C	D/C	D/C	D/C	20% after deductible		
Silver	86584WI0030022-00	$4,300	$8,600	20%	50%	$5,300	$18,600	D/C	D/C	D/C	D/C	D/C	20% after deductible		
Silver	86584WI0030016-00	$5,200	$10,400	0%	30%	$5,200	$16,400	D/C	D/C	D/C	D/C	D/C	No charge after deductible		
Bronze	86584WI0030017-00	$6,200	$12,400	30%	50%	$7,200	$22,400	D/C	D/C	D/C	D/C	D/C	30% after deductible		
Bronze	86584WI0030018-00	$7,200	$14,400	0%	30%	$7,200	$20,400	D/C	D/C	D/C	D/C	D/C	No charge after deductible		

Prescription Drugs: Preventive: $0; All others: deductible and coinsurance
Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

[1]Services performed out of network under the POS plan options are subject to the out-of-network deductible and coinsurance, except some emergency services. See policy for details.

[2]Non-Embedded Deductible and Out-of-Pocket Limit: This plan features a non-embedded deductible and out-of-pocket limit. If an employee has family coverage, the family deductible must be satisfied before this plan will pay benefits. One person can satisfy the family deductible. If an employee has family coverage, the family out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family out-of-pocket limit. Deductibles and out-of-pocket maximums apply annually.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.

2024 Small Group HMO Plan Summary

Health Maintenance Organization (HMO) Plans

		You Pay (In-Network Services)[2]										
Metal Tier	**SBC Lookup**	**Individual Deductible[1]**	**Coinsurance**	**Individual Annual Max Out of Pocket[1]**	**Emergency Room**	**MDLive Visit**	**Retail Clinic Visit**	**PCP Visit**	**Specialty Visit**	**Outpatient Lab/X-ray**	**Outpatient Surgery**	**Hospital**
Platinum	86584WI0040001-00	$400	20%	$2,270	D/C	$0	$10	$35	$70	20% after deductible		
Gold	86584WI0040002-00	$1,150	20%	$6,800	D/C	$0	$10	$35	$70	20% after deductible		
Gold	86584WI0040003-00	$1,700	10%	$7,600	D/C	$0	$10	$35	$70	10% after deductible		
Gold	86584WI0040005-00	$2,100	20%	$8,000	D/C	$0	$10	$35	$70	20% after deductible		
Gold	86584WI0040006-00	$2,600	20%	$4,600	D/C	$0	$10	$35	$70	20% after deductible		
Silver	86584WI0040009-00	$3,700	20%	$8,650	D/C	$0	$10	$45	$90	20% after deductible		
Silver	86584WI0040010-00	$4,500	10%	$9,050	D/C	$0	$10	$45	$90	10% after deductible		
Silver	86584WI0040011-00	$5,000	20%	$7,500	D/C	$0	$10	$45	$90	20% after deductible		
Silver	86584WI0040020-00	$7,000	30%	$9,050	D/C	$0	$10	$45	$90	30% after deductible		

Platinum Prescription Drugs: Preventive: $0; Tier 1: $15; Tier 2: $30; Tier 3: $60; Tier 4: 30% coinsurance

Gold Prescription Drugs: Preventive: $0; Tier 1: $15; Tier 2: $30; Tier 3: $60; Tier 4: 30% coinsurance

Silver Prescription Drugs: Preventive: $0; Tier 1: $25; Tier 2: $50; Tier 3: $80; Tier 4: $750 deductible, then 40% coinsurance

Preventive drugs include specific supplements, contraceptives, immunizations, and other preventive drugs ranked A or B by the U.S. Preventive Services Task Force.

[1]Family deductibles and out-of-pocket limits are 2x the individual amounts.

[2]Out-of-network services are not covered under HMO plan options, except in emergency situations. See policy for details.

Unless otherwise noted, plans have an Embedded Deductible and Embedded Out-of-Pocket Limit: These plans feature an embedded deductible where an individual deductible must be satisfied before this plan will pay benefits. These plans feature an embedded out-of-pocket limit where the individual out-of-pocket limit must be satisfied before this plan will pay 100% of covered benefits. Deductibles and out-of-pocket maximums apply annually.