ASPIRUS HEALTH PLAN

Coverage Period: Beginning on or after 01/01/2025

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

Coverage for: Individual + Family

HMO Silver 7000

Plan Type: HMO

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, visit www.aspirushealthplan.com. 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: $7,000/$14,000 (individual/family- $7,000 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 drugs . 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: $8,250/$16,500 (individual/family- $8,250 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: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	**Primary care visit to treat an injury or illness**	$45 copayment/visit and 30% coinsurance for other outpatient services; deductible does not apply to the office visit charge.	Not covered	$0 copayment/visit for online care with our approved online care provider. $10 copayment/visit for convenience care clinic visit. $45 copayment/visit for chiropractor.
	Specialist visit	$90 copayment/visit and 30% 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.
If you have a test	**Diagnostic test (x-ray, blood work)**	30% 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)	30% 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/	**Generic drugs**	Tier 1: Retail: $25 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.
	Preferred brand drugs	Tier 2: Retail: $50 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.
	Non-preferred brand drugs	Tier 3: Retail: $80 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 (specific deductible applies)	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.
If you have outpatient surgery	**Facility fee (e.g., ambulatory surgery center)**	30% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
	Physician/surgeon fees	30% coinsurance	Not covered	None
If you need immediate medical attention	**Emergency room services**	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	$45 copayment/urgent office visit and 30% coinsurance for other urgent care services; deductible does not apply to the urgent office visit charge.	$45 copayment/urgent office visit and 30% 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)**	30% 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	30% 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 30% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge.	Not covered	None
	Inpatient services	30% 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 30% 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	30% 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	30% 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.
If you need help recovering or have other special health needs	**Home health care**	30% coinsurance	Not covered	Coverage is limited to 60 visits/year.
	Rehabilitation services	$45 copayment/visit and 30% coinsurance for other	Not covered	Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; 20 visits/year for speech

Common Medical Event	Services You May Need	What You Will Pay: In-Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		outpatient services; deductible does not apply to the therapy office visit charge.		therapy.
	Habilitation services	$45 copayment/visit and 30% 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; No limit for speech and occupational therapy.
	Skilled nursing care	30% 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	30% 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	30% coinsurance	Not covered	Hospice services 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 when the life of the mother is endangered)
- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adults)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (except certain conditions)
- Weight loss programs (except preventive obesity counseling/screening)

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

- Chiropractic care
- Hearing aids
- Routine eye care (Adult)

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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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	$7,000
Specialist copayment	$90
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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**

In this example, Peg would pay:

Cost Sharing	
Deductibles	**$7000**
Copayments	**$10**
Coinsurance	**$1240**
What isn't covered	
Limits or Exclusions	**$60**
The total Peg would pay is	**$8,310**

Managing Joe's Type 2 Diabetes

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

The plan's overall deductible	$7,000
Specialist copayment	$90
Hospital (facility) coinsurance	30%
Other copayment	$25

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**

In this example, Joe would pay:

Cost Sharing	
Deductibles	**$900**
Copayments	**$800**
Coinsurance	**$0**
What isn't covered	
Limits or Exclusions	$20
The total Joe would pay is	**$1,720**

Mia's Simple Fracture

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

The plan's overall deductible	$7,000
Specialist copayment	$90
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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**

In this example, Mia would pay:

Cost Sharing	
Deductibles	**$2100**
Copayments	**$400**
Coinsurance	**$0**
What isn't covered	
Limits or Exclusions	**$0**
The total Mia would pay is	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. 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, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If *you* believe that Aspirus Health Plan, Inc. 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:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
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. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-866-631-5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف1-866-631-5404(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-631-5404 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-866-631-5404 (TTY: 711).

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: 711) 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: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-866-631-5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer1-866-631-5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-866-631-5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al1-866-631-5404 (TTY: 711).

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: 711).

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: 711)

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: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-631-5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-631-5404 (TTY: 711).

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