

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

**Coverage for:** Individual + Family

POS Silver 700 CSR 87

**Plan Type:** POS



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](http://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](http://www.healthcare.gov/sbc-glossary) or call 866-631-4611 to request a copy.

| Important Questions                                                             | Answers                                                                                                                                                                                     | Why This Matters:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |
|---------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| What is the overall <a href="#">deductible</a> ?                                | In-network: \$700/\$1,400 (individual/family-\$700 per family member). Out-of-network: \$12,000/\$24,000 (individual/family-\$12,000 per family member).                                    | Generally, you must pay all of the costs from providers up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family deductible.                                                                                                                                                                                                                            |
| Are there services covered before you meet your <a href="#">deductible</a> ?    | Yes. <a href="#">Preventive care</a> services are covered before you meet your deductible.                                                                                                  | This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain preventive services without <a href="#">cost-sharing</a> and before you meet your deductible. See a list of covered preventive services at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits/">www.healthcare.gov/coverage/preventive-care-benefits/</a> .                                                                                                                |
| Are there other <a href="#">deductibles</a> for specific services?              | No.                                                                                                                                                                                         | You don't have to meet <a href="#">deductibles</a> for specific services.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ? | In-network: \$3,300/\$6,600 (individual/family-\$3,300 per family member). Out-of-network: \$22,000/\$44,000 (individual/family-\$22,000 per family member).                                | The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.                                                                                                                                                                                                                                                                                                                                            |
| What is not included in the <a href="#">out-of-pocket limit</a> ?               | Premiums, balance-billing charges, and health care this <a href="#">plan</a> doesn't cover.                                                                                                 | Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| Will you pay less if you use a <a href="#">network provider</a> ?               | Yes. See <a href="https://p1.aspirushealthplan.com/find-a-doctor">https://p1.aspirushealthplan.com/find-a-doctor</a> or call 866-631-4611 for a list of <a href="#">network providers</a> . | This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the provider's charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services. |
| Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?    | No.                                                                                                                                                                                         | You can choose an in-network <a href="#">specialist</a> without a <a href="#">referral</a> .                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |



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                                   | In-Network Provider<br>(You will pay the least)                                                                                                                                             | Out-of-Network Provider<br>(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        | \$20 <a href="#">copayment</a> /visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge.              | 50% <a href="#">coinsurance</a>                    | \$20 <a href="#">copayment</a> /visit for telehealth visit charge with our approved telehealth provider. \$20 <a href="#">copayment</a> /visit for convenience care clinic visit. \$20 <a href="#">copayment</a> /visit for chiropractor.                  |
|                                                                                                                                                                                                                                             | <a href="#">Specialist</a> visit                        | \$40 <a href="#">copayment</a> /visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge.              | 50% <a href="#">coinsurance</a>                    | None                                                                                                                                                                                                                                                       |
|                                                                                                                                                                                                                                             | <a href="#">Preventive care/screening</a> /immunization | No charge ( <a href="#">deductible</a> does not apply)                                                                                                                                      | Not covered                                        | You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.                                                                  |
| If you have a test                                                                                                                                                                                                                          | Diagnostic test (x-ray, blood work)                     | 30% <a href="#">coinsurance</a>                                                                                                                                                             | 50% <a href="#">coinsurance</a>                    | 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% <a href="#">coinsurance</a>                                                                                                                                                             | 50% <a href="#">coinsurance</a>                    | 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<br>More information about prescription drug coverage is available at <a href="https://aspirushealthplan.com/resources/pharmacy/">https://aspirushealthplan.com/resources/pharmacy/</a> | Generic drugs                                           | Tier 1: Retail: \$10 <a href="#">copayment</a> /prescription (30-day supply) Retail and mail: 2.5 times the retail <a href="#">copayment</a> /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 <a href="#">out-of-pocket limit</a> . |
|                                                                                                                                                                                                                                             | Preferred brand drugs                                   | Tier 2: Retail: \$20 <a href="#">copayment</a> /prescription (30-day supply) Retail and mail: 2.5 times the retail <a href="#">copayment</a> /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 <a href="#">out-of-pocket limit</a> . |
|                                                                                                                                                                                                                                             | Non-preferred brand drugs                               | Tier 3: Retail: Deductible, then \$60 <a href="#">copayment</a> /prescription (30-day supply) Retail and mail: 2.5 times the retail <a href="#">copayment</a> /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 <a href="#">out-of-pocket limit</a> . |
|                                                                                                                                                                                                                                             | <a href="#">Specialty drugs</a>                         | Retail and mail: Deductible, then \$250 <a href="#">copayment</a> /prescription ( <a href="#">deductible</a> does not apply)                                                                | Not covered                                        | <a href="#">Specialty drugs</a> are limited to a 30-day supply. <a href="#">Specialty drugs</a> 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.   |

| Common Medical Event                                                      | Services You May Need                            | What You Will Pay                                                                                                                                                                  |                                                                                                                                                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                                                                                                                                                  |
|---------------------------------------------------------------------------|--------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                           |                                                  | In-Network Provider<br>(You will pay the least)                                                                                                                                    | Out-of-Network Provider<br>(You will pay the most)                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                         |
| If you have outpatient surgery                                            | Facility fee (e.g., ambulatory surgery center)   | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                    |
| If you need immediate medical attention                                   | <a href="#">Emergency room services</a>          | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 30% <a href="#">coinsurance</a>                                                                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Emergency medical transportation</a> | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 30% <a href="#">coinsurance</a>                                                                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | <a href="#">Urgent care</a>                      | \$30 <a href="#">copayment</a> /urgent office visit and 30% <a href="#">coinsurance</a> for other <a href="#">urgent care</a> services; <a href="#">deductible</a> does not apply. | \$30 <a href="#">copayment</a> /urgent office visit and 30% <a href="#">coinsurance</a> for other <a href="#">urgent care</a> services; <a href="#">deductible</a> does not apply. | <a href="#">Urgent care</a> professional charges may be subject to the \$40 <a href="#">specialist</a> office visit <a href="#">copayment</a> depending on the specialty of the physician providing treatment.                                                                                                                                                                                                                          |
| If you have a hospital stay                                               | Facility fee (e.g., hospital room)               | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.                                                                                                                                                                                                                                                                                                |
|                                                                           | Physician/surgeon fees                           | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | 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                              | \$20 <a href="#">copayment</a> /visit                                                                                                                                              | 50% <a href="#">coinsurance</a>                                                                                                                                                    | None                                                                                                                                                                                                                                                                                                                                                                                                                                    |
|                                                                           | Inpatient services                               | 30% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | 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                                    | \$20 <a href="#">copayment</a> /visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge.     | 50% <a href="#">coinsurance</a>                                                                                                                                                    | Cost sharing does not apply to certain preventive services. Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , <a href="#">deductible</a> 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% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | Cost sharing does not apply to certain preventive services. Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , <a href="#">deductible</a> 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% <a href="#">coinsurance</a>                                                                                                                                                    | 50% <a href="#">coinsurance</a>                                                                                                                                                    | Cost sharing does not apply to certain preventive services. Depending on the type of services, <a href="#">copayment</a> , <a href="#">coinsurance</a> , <a href="#">deductible</a> 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                |

| Common Medical Event                                           | Services You May Need                     | What You Will Pay                                                                                                                                                              |                                                    | Limitations, Exceptions, & Other Important Information                                                                                                                                                                                                                                                            |
|----------------------------------------------------------------|-------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|                                                                |                                           | In-Network Provider<br>(You will pay the least)                                                                                                                                | Out-of-Network Provider<br>(You will pay the most) |                                                                                                                                                                                                                                                                                                                   |
| If you need help recovering or have other special health needs |                                           |                                                                                                                                                                                |                                                    | authorization.                                                                                                                                                                                                                                                                                                    |
|                                                                | <a href="#">Home health care</a>          | 30% <a href="#">coinsurance</a>                                                                                                                                                | 50% <a href="#">coinsurance</a>                    | Coverage is limited to 60 visits/year.                                                                                                                                                                                                                                                                            |
|                                                                | <b>Rehabilitation services</b>            | \$20 <a href="#">copayment</a> /visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge. | 50% <a href="#">coinsurance</a>                    | Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; 20 visits/year for speech therapy.                                                                                                                                                                           |
|                                                                | <a href="#">Habilitation services</a>     | \$20 <a href="#">copayment</a> /visit and 30% <a href="#">coinsurance</a> for other outpatient services; <a href="#">deductible</a> does not apply to the office visit charge. | 50% <a href="#">coinsurance</a>                    | Coverage is limited to 20 visits/year for physical therapy; No limit for speech and occupational therapy.                                                                                                                                                                                                         |
|                                                                | <a href="#">Skilled nursing care</a>      | 30% <a href="#">coinsurance</a>                                                                                                                                                | 50% <a href="#">coinsurance</a>                    | 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.                                                                                                          |
|                                                                | <a href="#">Durable medical equipment</a> | 30% <a href="#">coinsurance</a>                                                                                                                                                | 50% <a href="#">coinsurance</a>                    | 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. |
| If your child needs dental or eye care                         | <b>Hospice service</b>                    | 30% <a href="#">coinsurance</a>                                                                                                                                                | 50% <a href="#">coinsurance</a>                    | <a href="#">Hospice services</a> require prior authorization. Benefits may not be payable if you do not obtain prior authorization.                                                                                                                                                                               |
|                                                                | <b>Children's eye exam</b>                | No charge ( <a href="#">deductible</a> does not apply)                                                                                                                         | Not covered                                        | Coverage limited to one exam/year.                                                                                                                                                                                                                                                                                |
|                                                                | <b>Children's glasses</b>                 | No charge ( <a href="#">deductible</a> does not apply)                                                                                                                         | Not covered                                        | Coverage limited to one pair of glasses/year.                                                                                                                                                                                                                                                                     |
|                                                                | <b>Children's dental check-up</b>         | 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                                                 | • 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](http://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](http://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 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 the Minimum Value Standards? N/A

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](#) \$700
- [Specialist copayment](#) \$40
- 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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$700   |
| <a href="#">Copayments</a>  | \$0     |
| <a href="#">Coinsurance</a> | \$2600  |
| What isn't covered          |         |
| Limits or Exclusions        | \$60    |
| The total Peg would pay is  | \$3,360 |

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$700
- [Specialist copayment](#) \$40
- Hospital (facility) [coinsurance](#) 30%
- Other [copayment](#) \$10

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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$700   |
| <a href="#">Copayments</a>  | \$500   |
| <a href="#">Coinsurance</a> | \$60    |
| What isn't covered          |         |
| Limits or Exclusions        | \$20    |
| The total Joe would pay is  | \$1,280 |

Mia's Simple Fracture

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

- The [plan's](#) overall [deductible](#) \$700
- [Specialist copayment](#) \$40
- 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                |         |
|-----------------------------|---------|
| <a href="#">Deductibles</a> | \$700   |
| <a href="#">Copayments</a>  | \$200   |
| <a href="#">Coinsurance</a> | \$400   |
| What isn't covered          |         |
| Limits or Exclusions        | \$0     |
| The total Mia would pay is  | \$1,300 |

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](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 أعلى رقم الهاتف 1-866-631-5404 (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 zur Verfügung. 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 numer 1-866-631-5404 (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 al 1-866-631-5404 (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 Deutsch (Pennsylvania German / Dutch) schwetzsch, kannst 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີຮ່ອມໃຫ້ທ່ານ. ໂທ 1-866-631-5404 (TTY: 711).