

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

Coverage for: Individual + Family

Aspirus Health Plan Easy Compare Silver and RX Copay Autograph CSR 73

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 866-631-4611 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-network: \$2,800 individual / \$5,600 family. 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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-network: \$8,400 individual / \$16,800 family. 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 866-631-4611 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.

		What You Will Pay		Limitations, Exceptions, & Other Important Information
Common Medical Event	Services You May Need	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	First four office visits free; thereafter, you pay \$50 copayment /visit and 30% coinsurance for other outpatient services; deductible does not apply to the office visit charge.	Not covered	First four free primary care office visit benefit is combined for all in- network providers for each member. \$50 copayment /visit for telehealth visit charge with our approved telehealth provider. 30% coinsurance after deductible for convenience care clinic visit. \$50 copayment /visit for chiropractor. Deductible does not apply to the office visit charges.
	Specialist visit	\$120 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	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://aspirushealthplan.com/resources/pharmacy/	Generic drugs	Tier 1: Retail: \$20 copayment /prescription (30-day supply) Retail and mail: 2.5 times the retail copayment /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 . You will pay no more than \$25 per month for each prescription for eligible drugs to treat certain chronic diseases. You may need to meet your deductible first. The value of drug coupons you use will count towards cost sharing or out-of-pocket limits . Designated ACA preventive drugs (including OTC drugs) with a prescription are covered with no member cost sharing . Drugs and drug tiers on the covered drug list may change with notice. May require prior authorization.
	Preferred brand drugs	Tier 2: Retail: \$40 copayment /prescription (30-day supply) Retail and mail: 2.5 times the retail copayment /prescription (90-day supply)	Not covered	
	Non-preferred brand drugs	Tier 3: Retail: \$120 copayment /prescription (30-day supply) Retail and mail: 2.5 times copayment /prescription (90-day supply)	Not covered	
	Specialty drugs	Retail and mail: \$480 copayment /prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g.,	30% coinsurance	Not covered	None

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)	
	ambulatory surgery center)			
	Physician/surgeon fees	30% coinsurance	Not covered	
If you need immediate medical attention	Emergency room services	30% coinsurance	30% coinsurance	In-network deductible applies to out-of-network care.
	Emergency medical transportation	30% coinsurance	30% coinsurance	
	Urgent care	\$90 copayment /urgent office visit and 30% coinsurance for other urgent care services; deductible does not apply.	Not covered	Urgent care professional charges may be subject to the \$120 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	First four office visits free; thereafter, you pay \$50 copayment /visit and 30% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge.	Not covered	First four free primary care office visit benefit is combined for all in- network providers for each member. \$50 copayment /visit for telehealth visit charge with our approved telehealth provider.
	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	First four office visits free; thereafter, you pay \$50 copayment /visit and 30% coinsurance for other outpatient services; deductible does not apply to the office visit charge.	Not covered	First four primary care office visit benefit is combined for all in- network providers for each member. 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
	Childbirth/delivery facility services	30% coinsurance	Not covered	

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				authorization.
	Home health care	30% coinsurance	Not covered	Coverage is limited to 60 visits/year.
	Rehabilitation services	\$60 copayment /visit and 30% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge.	Not covered	None
	Habilitation services	\$60 copayment /visit and 30% coinsurance for other outpatient services; deductible does not apply to the therapy office visit charge.	Not covered	
	Skilled nursing care	30% coinsurance	Not covered	
	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 .)			
• Acupuncture	• Bariatric surgery	• Cosmetic surgery	• Dental care (Adults)
• Infertility treatment	• Long-term care	• Non-emergency care when traveling outside the U.S.	• Non-formulary drugs without a formulary exception (or Drugs not on the covered drug list unless an exception is obtained)
• 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.)		
• Abortion	• 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: Aspirus Health Plan at 1 (866) 631-4611 or the Minnesota Department of Health at 651-201-5100 or 800-657-3916. 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.mnsure.org or call 651-539-2099 or 855-366-7873.

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 the Minnesota Department of Health at 651-201-5100 or 800-657-3916.

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.

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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](#) \$2,800
- [Specialist copayment](#) \$120
- 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	\$2,800
Copayments	\$0
Coinsurance	\$5,600
What isn't covered	
Limits or Exclusions	\$60
The total Peg would pay is	\$8,460

Managing Joe's Type 2 Diabetes

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

- The [plan's](#) overall [deductible](#) \$2,800
- [Specialist copayment](#) \$120
- Hospital (facility) [coinsurance](#) 30%
- Other [coinsurance](#) 30%

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](#) \$2,800
- [Specialist copayment](#) \$120
- 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	\$2,100
Copayments	\$600
Coinsurance	\$0
What isn't covered	
Limits or Exclusions	\$0
The total Mia would pay is	\$2,700

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/90006-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.866.631.5404 (TTY: 711).

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).

Cushitic-Oromo: XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 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).

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).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1.866.631.5404 (телетайп: 711).

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອ ອັດຕະໂນມາສາ, ໂດຍບໍ່ເສັຍຄ່າ, ຄຸ້ມຄອງມີພ້ອມໃຫ້ທ່ານ. ໂທ 1.866.631.5404 (TTY: 711).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1.866.631.5404 (መስማት ለተሳናቸው: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1.866.631.5404 (TTY: 711).

Khmer/Cambodian: ឱ្យយក៖ បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយផ្នែកភាសា គឺធរនសេរីសេរី។
☎ ទូរស័ព្ទ 1.866.631.5404 (TTY: 711)។

Arabic: (711) اتصل برقم إذا كنت تتحدث انكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان: ملحوظة 1.866.631.5404 رقم: هاتف الصم والبكم

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1.866.631.5404 (ATS: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1.866.631.5404 (TTY: 711) 번으로 전화해 주십시오.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1.866.631.5404 (TTY: 711).

Karen: သတိပြုရန်: သင်က ကရင်ဘာသာ ပြောဆိုသူဖြစ်ပါက၊ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို အခမဲ့ လက်ခံနိုင်ပါသည်။
ဖုန်းခေါ်ပါ 1.866.631.5404 (TTY: 711).