

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
HMO HDHP Bronze 0 CSR Zero


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 ? | \$0 | See the Common Medical Events chart below for your costs for services this plan covers. |
| Are there services covered before you meet your deductible ? | Yes. | This plan covers some items and services even if you haven't yet met the deductible amount. |
| 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 ? | Not applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| What is not included in the out-of-pocket limit ? | Not applicable. | This plan does not have an out-of-pocket limit on your expenses. |
| Will you pay less if you use a network provider ? | Not applicable. | This plan does not have a provider network . You can receive covered services from any provider. |
| Do you need a referral to see a specialist ? | No. | You can choose an in-network specialist without a referral . |

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

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Indian Health Care Provider (IHCP) (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 | No charge | Not covered | None |
| | Specialist visit | No charge | Not covered | None |
| | Preventive care/screening/immunization | No charge | 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) | No charge | 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) | No charge | 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://aspirushealthplan.com/resources/pharmacy/ | Generic drugs | Tier 1: No charge Tier 2: No charge Tier 3: No charge | 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 . |
| | Preferred brand drugs | Tier 1: No charge Tier 2: No charge Tier 3: No charge | 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 1: No charge Tier 2: No charge Tier 3: No charge | 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 | No charge | Not covered | Specialty drugs are limited to a 30-day supply. Specialty drugs and drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |

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|---------------------------------------------------------------------------|--------------------------------------------------|----------------------------------------------------------------|----------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | No charge | Not covered | None |
| | Physician/surgeon fees | No charge | Not covered | None |
| If you need immediate medical attention | Emergency room services | No charge | No charge | None |
| | Emergency medical transportation | No charge | No charge | None |
| | Urgent care | No charge | No charge | None |
| If you have a hospital stay | Facility fee (e.g., hospital room) | No charge | 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 | No charge | 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 | No charge | Not covered | Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. |
| | Inpatient services | No charge | Not covered | 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 | No charge | Not covered | 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 | No charge | Not covered | 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 | No charge | Not covered | 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 | No charge | Not covered | Coverage is limited to 60 visits/year. |
| | Rehabilitation services | No charge | Not covered | Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; 20 visits/year for speech therapy. |
| | Habilitation services | No charge | Not covered | Coverage is limited to 20 visits/year for physical therapy; 20 visits/year for occupational therapy; 20 visits/year for speech therapy. |
| | Skilled nursing care | No charge | 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 | No charge | 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 |

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|----------------------|---------------------------------|----------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | | | | prior authorization. |
| | Hospice service | No charge | Not covered | Hospice service s 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 |
|----------------------------------------|----------------------------|----------------------------------------------------------------|----------------------------------------------------|--------------------------------------------------------|
| | | Indian Health Care Provider (IHCP) (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Coverage limited to one exam/year. |
| | Children's glasses | No charge | 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 .) | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> • Abortion (except in the cases of rape, incest, or when the life of the mother is endangered) • Cosmetic surgery • Long-term care • Routine eye care (Adult) | <ul style="list-style-type: none"> • Acupuncture • Dental care • Non-emergency care when traveling outside the U.S. • Routine foot care | <ul style="list-style-type: none"> • Bariatric surgery • Infertility treatment • Private-duty nursing • 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. 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 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?

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 866-631-4611.

Hmong (Hmoob): Kev pab nyob rau hauv Hmoob hu 866-631-4611.

Traditional Chinese (傳統中文): 有關中文協助,請致電 866-631-4611.

German (Deutsch): Für Hilfe in deutscher Sprache rufen 866-631-4611.

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 | \$0 |
| ■ Specialist copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or Exclusions | \$60 |
| The total Peg would pay is | \$60 |

Managing Joe's Type 2 Diabetes

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

| | |
|-----------------------------------------------------------------|-----|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or Exclusions | \$30 |
| The total Joe would pay is | \$30 |

Mia's Simple Fracture

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

| | |
|-----------------------------------------------------------------|-----|
| ■ The plan's overall deductible | \$0 |
| ■ Specialist copayment | \$0 |
| ■ Hospital (facility) coinsurance | 0% |
| ■ Other coinsurance | 0% |

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 | \$0 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| What isn't covered | |
| Limits or Exclusions | \$0 |
| The total Mia would pay is | \$0 |

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

Nondiscrimination & Language Access Policy

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

We will:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If *you* need these services, contact *us* at the phone number shown on the inside cover of this *COC*, *your* id card, or aspirushealthplan.com.

If *you* believe that *we* have failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity, *you* can file a grievance with:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1062
Minneapolis, MN 55440
Phone: 1. 866.631.4611 (TTY: 763.847.4013)
Fax: 763.847.4400
Email: customerservice@aspirushealthplan.com

You can file a grievance in person or by mail, fax, or email. If *you* need help filing a grievance, the Nondiscrimination Grievance Coordinator is available to help *you*.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

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

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

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-332-6501 (TTY: 763.847.4013).

Arabic: تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن أعلى رقم الهاتف 1-800-332-6501 (رقم هاتف الصم والبك : 763.847.4013)

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelezle 1-800-332-6501 (ATS : 763.847.4013).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-6501 (TTY: 763.847.4013).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_ |1-800-332-6501 (TTY: 763.847.4013) 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 1-800-332-6501 (TTY: 763.847.4013).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-6501 (TTY: 763.847.4013)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-6501 (TTY: 763.847.4013).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-6501 (телетайп: 763.847.4013).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-6501 (TTY: 763.847.4013).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 763.847.4013).

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 1-800-332-6501 (TTY: 763.847.4013)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 763.847.4013).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kannschd du mitaus Koschte ebergerricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 763.847.4013).

Lao: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ຈຳນວນມີຈຳນວນໃຫ້ທ່ານ. ໂທ 1-800-332-6501 (TTY: 763.847.4013).