



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, at www.aspirusrise.com or call 1-800-223-6895. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other undefined terms see the Glossary. You can view the Glossary at <https://www.healthcare.gov/sbc-glossary/> or call 1-800-223-6895 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For preferred providers: \$1,500/Single Coverage or \$3,000/Family Coverage; For non-preferred providers: \$1,500/Single Coverage or \$3,000/Family 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, the overall family deductible, must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	Yes. Preventive care services 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 https://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?	For preferred providers: \$2,100/Single Coverage or \$4,200/Family Coverage. For non-preferred providers: \$4,200 Single Coverage or \$8,400/Family 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, the overall family out-of-pocket limit must be 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://secure.wecareforwisconsin.com/aspirus/raise/find_a_doctor/ or call 1-800-223-6895 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 see the specialist you choose 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
		Participating Provider (You will pay the least)	Non-Participating 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	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Telehealth visits through Teladoc are covered
	Specialist visit	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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 you need are preventive. Then check what your plan will pay for. You also have no charge for immunizations provided by a non-participating provider.
If you have a test	Diagnostic test (x-ray, blood work)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at https://www.aspirusarise.com/wps/portal/whi/aspinus-arise/resources/drug-formulary/	Generic drugs	10% <u>coinsurance</u>	Not covered	Covers up to a 90-day supply retail/home delivery; however, specialty drugs are always limited to a 30-day supply. If brand dispensed when generic available, you are responsible for dollar amount difference between brand and generic. 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.
	Preferred brand drugs	10% <u>coinsurance</u>	Not covered	
	Non-preferred brand drugs	10% <u>coinsurance</u>	Not covered	
	Specialty drugs	10% <u>coinsurance</u>	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None
If you need immediate medical attention	Emergency room care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	None
	Emergency medical transportation	10% <u>coinsurance</u>	10% <u>coinsurance</u>	
	Urgent care	10% <u>coinsurance</u>	10% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization. All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Inpatient services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
If you are pregnant	Office visits	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Cost sharing does not apply to certain preventive services. Depending on the type of services, <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery professional services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Childbirth/delivery facility services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Home health care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
	Rehabilitation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	
Habitatation services	10% <u>coinsurance</u>	30% <u>coinsurance</u>	None	
If you need help recovering or have other special health needs	Skilled nursing care	10% <u>coinsurance</u>	30% <u>coinsurance</u>	Coverage is limited to 30 days per confinement in a skilled nursing facility. All non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Prior authorization required for: • All CPAP purchases and rentals • Purchases over \$1,000 • All other rentals as stated on our website Benefits may not be payable if you do not obtain prior authorization.
	Durable medical equipment	10% <u>coinsurance</u>	30% <u>coinsurance</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<u>Hospice services</u>	10% <u>coinsurance</u>	30% <u>coinsurance</u>	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	Not covered	Coverage only for Participating Providers
	Children's glasses	Not covered	Not covered	Not Covered
	Children's dental check-up	Not covered	Not covered	Not Covered

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"> • Acupuncture • Bariatric Surgery • Cosmetic Surgery • Infertility Treatment 	<ul style="list-style-type: none"> • Long Term Care • Non-emergency care when traveling outside the U.S. • Private Duty Nursing • Routine Foot Care (unless associated with a specific medical diagnosis) • Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)	
<ul style="list-style-type: none"> • Chiropractic Care 	<ul style="list-style-type: none"> • Dental Care (adult), limited to certain oral surgical procedures, treatment of an injury, and extraction of teeth and sealants on existing teeth related to treatment of neoplastic disease • Hearing aids, limited to the cost of one hearing aid, per ear, for each member under age 18 every three years • Routine eye care, limited to eye exams

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 U.S. Department of Labor, Employee Benefits Security Administration 1-866-444-3272 or www.dol.gov/ebsa, or the Department of Health and Human Services at 1-877-267-2323 x 61565 or www.cchio.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 Arise at 1-800-223-6895. You may also contact your state insurance department at 1-800-236-8517 or the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

_____ To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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 \$1,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

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 \$12,800

In this example, Peg would pay:
 Cost Sharing

Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$600

What isn't covered

Limits or exclusions	\$10
----------------------	------

The total Peg would pay is \$2,110

Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 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 \$7,400

In this example, Joe would pay:
 Cost Sharing

Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$600

What isn't covered

Limits or exclusions	\$0
----------------------	-----

The total Joe would pay is \$2,100

Mia's Simple Fracture

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

- The plan's overall deductible \$1,500
- Specialist coinsurance 10%
- Hospital (facility) coinsurance 10%
- Other coinsurance 10%

This EXAMPLE event includes services like:
 Emergency room care (including medical supplies)
 Diagnostic test (x-ray)
 Durable medical equipment (crutches)
 Rehabilitation services (physical therapy)

Total Example Cost \$1,900

In this example, Mia would pay:
 Cost Sharing

Deductibles	\$1,500
Copayments	\$0
Coinsurance	\$50

What isn't covered

Limits or exclusions	\$0
----------------------	-----

The total Mia would pay is \$1,550

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