ASPIRUS HEALTH PLAN

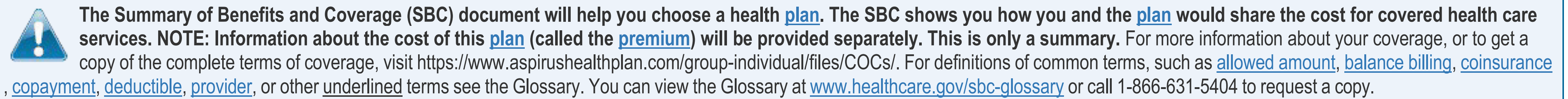
Coverage Period: Beginning on or after 01/01/2023

Coverage for: Individual/Family

Plan Type: PPO

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

Aspirus Inc.



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 https://www.aspirushealthplan.com/group-individual/files/COCs/. 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 1-866-631-5404 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	ANI Network: $1,500/$3,000 (individual/family) Signature Network: $1,750/$3,500 (individual/family) Out-of-network: $7,500/$15,000 (individual/family)	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 policy, 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, office visits, and prescription drugs 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?	ANI Network: $3,000/$6,000 (individual/family) Signature Network: $3,500/$7,000 (individual/family) Out-of-network: $10,000/$20,000 (individual/family)	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://p1.aspirushealthplan.com/find-a-doctor/ or call 1-866-631-5404 for a list of network providers.	This plan uses a tiered provider network. You will pay the least if you use a provider in the ANI Preferred network. You pay more if you use a Signature network provider. 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
		ANI Preferred Network (You will pay the least)	Signature Network (You will pay more)	Out-of-Network (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	$25 copayment/visit; deductible does not apply to the office visit charge.	$30 copayment/visit; deductible does not apply to the office visit charge.	50% coinsurance	$25 copayment/visit for Abbotsford and Medford Walk-in retail clinic. Copays apply for chiropractic visits.
	Specialist visit	$50 copayment/visit; deductible does not apply to the office visit charge.	$60 copayment/visit; deductible does not apply to the office visit charge.	50% coinsurance	None
	Preventive care/ screening/immunization	No charge (deductible does not apply)	No charge (deductible does not apply)	50% coinsurance	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)	15% coinsurance	20% coinsurance	50% coinsurance	Genetic testing requires prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Imaging (CT/PET scans, MRIs)	Deductible, 15% coinsurance, and $150 copayment per occurrence of back/hips/knee. All other imaging deductible and 15% coinsurance.	Deductible, 20% coinsurance, and $150 copayment per occurrence of back/hips/knee. All other imaging deductible and 20% coinsurance.	Deductible, 50% coinsurance, and $150 copayment per occurrence of back/hips/knee. All other imaging deductible and 50% coinsurance.	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider	Non-Participating Provider	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.aspirushealthplan.com/group-individual/resources/pharmacy/	**Tier 1 drugs**	Up to a 31 day supply: $10 copayment or cost, whichever is less/prescription. 31-93 day supply: $20 copayment or cost, whichever is less/prescription.	Not covered	Deductible does not apply to prescription drugs purchased from a pharmacy. If you choose a non-participating pharmacy, you are responsible for payment. Maintenance medications are required to be dispensed in a 90 day supply through Aspirus Retail Pharmacy or Aspirus Mail Order.
	Tier 2 drugs	Up to a 31 day supply: 20% to a maximum of $50 copayment/prescription. 31-93 day supply: 20% to a maximum of $100 copayment/prescription.	Not covered	Deductible does not apply to prescription drugs purchased from a pharmacy. If you choose a non-participating pharmacy, you are responsible for payment. Maintenance medications are required to be dispensed in a 90 day supply through Aspirus Retail Pharmacy or Aspirus Mail Order.
	Tier 3 drugs	Up to a 31 day supply: 30% to a maximum of $75 copayment/prescription. 31-93 day supply: 30% up to a maximum of $150 copayment/prescription.	Not covered	Deductible does not apply to prescription drugs purchased from a pharmacy. If you choose a non-participating pharmacy, you are responsible for payment. Maintenance medications are required to be dispensed in a 90 day supply through Aspirus Retail Pharmacy or Aspirus Mail Order.
	Specialty drugs	Up to a 31 day supply: 20% to a maximum $150 copayment/prescription 31-93 day supply: Not Applicable	Not covered	Specialty drugs are limited to a 30-day supply.

Common Medical Event	Services You May Need	What You Will Pay ANI Preferred Network (You will pay the least)	Signature Network (You will pay more)	Out-of-Network (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	20% coinsurance	50% coinsurance	Deductible applies.
	Physician/surgeon fees	15% coinsurance	20% coinsurance	50% coinsurance	Deductible applies.
If you need immediate medical attention	Emergency room services	$300 copayment/emergency room charge and deductible and 15% coinsurance for other emergency room services			The participating provider deductible applies to Emergency room care and emergency medical transportation provided by both participating and non-participating providers.
	Emergency medical transportation	15% coinsurance			The participating provider deductible applies to Emergency room care and emergency medical transportation provided by both participating and non-participating providers.
	Urgent care	$50 copayment/urgent care visit; deductible does not apply	$60 copayment/urgent care visit; deductible does not apply	50% coinsurance	The deductible is waived for an urgent care office visit provided by a participating provider.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	20% coinsurance	50% coinsurance	Deductible applies. All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Physician/surgeon fees	15% coinsurance	20% coinsurance	50% coinsurance	Deductible applies. All 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	$25 copayment/visit; deductible does not apply to the office visit charge.	$30 copayment/visit; deductible does not apply to the office visit charge.	50% coinsurance	None
	Inpatient services	15% coinsurance	20% coinsurance	50% coinsurance	All non-emergent inpatient hospital stays 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
		ANI Preferred Network (You will pay the least)	Signature Network (You will pay more)	Out-of-Network (You will pay the most)	
If you are pregnant	Office visits	$25 copayment/visit; deductible does not apply to the office visit charge.	$30 copayment/visit; deductible does not apply to the office visit charge.	50% coinsurance	Cost sharing does not apply for 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).
	Childbirth/delivery professional services	15% coinsurance	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Childbirth/delivery facility services	15% coinsurance	20% coinsurance	50% coinsurance	Cost sharing does not apply to certain preventive services. Depending on the type of services, copayment, coinsurance, deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). Non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	20% coinsurance	50% coinsurance	Coverage is limited to 40 visits/year.
	Rehabilitation services	$25 copayment/visit; deductible does not apply	$30 copayment/visit; deductible does not apply	50% coinsurance	Physical/Speech/Occupational therapy is limited to 40 visits per calendar year. Aquatic therapy is limited to 20 visits per calendar year. Physical/Speech/Occupational therapy provided by a non-participating provider requires prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Habilitation services	$25 copayment/visit; deductible does not apply	$30 copayment/visit; deductible does not apply	50% coinsurance	Physical/Speech/Occupational therapy is limited to 40 visits per calendar year. Aquatic therapy is limited to 20 visits per calendar year. Physical/Speech/Occupational therapy provided by a non-participating provider requires prior authorization. Benefits may not be payable if you do not obtain prior authorization.

	Skilled nursing care	15% coinsurance	20% coinsurance	50% coinsurance	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.
	Durable medical equipment	15% coinsurance	20% coinsurance	50% coinsurance	Prior authorization required for: - All CPAP purchases and rentals - Purchases over $1,000 - Rentals over $750 Benefits may not be payable if you do not obtain prior authorization.
	Hospice service	15% coinsurance	20% coinsurance	50% coinsurance	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)	No charge (deductible does not apply)	50% coinsurance	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	Not covered	None

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.)

- Cosmetic Surgery
- Infertility treatment
- Private-duty nursing (except ventilator dependents)
- Routine foot care (except certain conditions)
- Long-term care
- Dental Care (Adults)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs (except preventive obesity counseling/screening)

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

- Acupuncture
- Chiropractic care
- Hearing aids (every 3 years, up to age 19)
- Bariatric Surgery
- Routine eye care (Adult)

Your rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for the agency is the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform. 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, you can contact PreferredOne Customer Service at 763.847.4477 / 800.997.1750 or the Department of Labor's Employee Benefits Security Administration at 1.866.444.EBSA (3272) /www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

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

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 763.847.4477 / 800.997.1750]

[Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 763.847.4477 / 800.997.1750]

[Chinese (中文): 如果需要中文的□助 763.847.4477 / 800.997.1750]

[Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 763.847.4477 / 800.997.1750]

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 ANI Preferred network pre-natal care and a hospital delivery)

- The plan's overall deductible $1,500
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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	**$1,500**
Copayments	**$0**
Coinsurance	**$1,500**
What isn't covered	
Limits or Exclusions	**$60**
The total Peg would pay is	**$3,060**

Managing Joe's Type 2 Diabetes
(a year of routine ANI Preferred network care of a well-controlled condition)

- The plan's overall deductible $1,500
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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	**$1,430**
Copayments	**$590**
Coinsurance	**$975**
What isn't covered	
Limits or Exclusions	$50
The total Joe would pay is	**$3,050**

Mia's Simple Fracture
(ANI Preferred network emergency room visit and follow up care)

- The plan's overall deductible $1,500
- Specialist coinsurance 15%
- Hospital (facility) coinsurance 15%
- Other coinsurance 15%

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	**$1,200**
Copayments	**$510**
Coinsurance	**$210**
What isn't covered	
Limits or Exclusions	**$0**
The total Mia would pay is	**$1,920**

Note: These numbers assume the patient received care from an **ANI Preferred Network** provider. If you receive care from other providers your costs may be higher.

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 اعلى رقم الهاتف1-800-332-6501(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 zurVerfügung. 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 numer1-800-332-6501 (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) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 763.847.4013).

Lao: ໂປດຊາບ: ຖ້ າວ່ າ ທ່ ານເວົ ້ າພາສາ ລາວ, ການບໍລິການຊ່ ອດ້ ານພາສາ,ໂດຍບໍ່ເສັ ຽຄ່ າ, ແມ່ ນມີພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-800-332-6501 (TTY:
ວຍເຫືອ
763.847.4013).