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 or call 1-866-631-5404. For general 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 https://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?	For participating providers: $500/Covered Person or $1,000/Family; For non-participating providers: $500/Covered Person or $1,000/Family.	Generally, you must pay all of the costs from providers, up to the deductible amount before this plan beings 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 expense paid by all family members meets the overall family deductible. Non-participating provider deductible amounts credit toward participating provider deductible amounts.
Are there services covered before you meet your deductible?	Yes. Preventive care services, office visits and prescription drugs purchased from a pharmacy are covered before you meet your deductible.	This plan covers some items and services even if you have not 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 do not have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For participating providers; $2,000/Covered Person or $4,000/Family (excluding copayments), up to a maximum out-of-pocket (including copayments) of $7,350 Person/$14,700 Family for participating providers; For non-participating providers: $3,000/Covered Person or $6,000 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, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. Non-participating provider out-of-pocket amounts credit toward participating provider out-of-pocket amounts.

* For more information about limitations and exceptions, see the plan or Summary Plan Description at www.aspirushealthplan.com.

Important Questions	Answers	Why This Matters:
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 do not count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aspirushealthplan.com/group or call 1-866-631-5404 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in 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*
		Signature Network 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% coinsurance	30% coinsurance	
	Specialist visit	10% coinsurance	30% coinsurance	----------None----------
	Preventive care/screening/ immunization	No charge	30% coinsurance	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	30% coinsurance	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% coinsurance	30% coinsurance	

* For more information about limitations and exceptions, see the plan or Summary Plan Description at www.aspirushealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aspirushealthplan.com/group	Tier 1 drugs	$5 copayment/ prescription (retail) & $5 copayment/ (home delivery)	$5 copayment/ prescription (retail) & $5 copayment/ (home delivery)	Provider means pharmacy for purposes of this section. Covers up to a 90-day supply retail/90-day supply home delivery. If brand is dispensed when a generic is available, you are responsible for the cost difference between the brand and generic which, unless your physician specifically instructs to dispense the brand drug 'as written'. The difference does not count toward your out–of–pocket limit. Drugs provided by an entity other than a pharmacy require prior authorization. Benefits may not be payable if you do not obtain prior authorization. Diabetic supplies and certain preventive medications are covered at 100%.
	Tier 2 drugs	$20 copayment/ prescription (retail) & $20 copayment/ (home delivery)	$20 copayment/ prescription (retail) & $20 copayment/ (home delivery)	
	Tier 3 drugs	$40 copayment/ prescription (retail) & $40 copayment/ (home delivery)	$40 copayment/ prescription (retail) & $40 copayment/ (home delivery)	
	Specialty drugs	25% of the drug up to a $100 copayment per prescription -both retail & home delivery *(limited to 30-day supply)*	25% of the drug up to a $100 copayment per prescription -both retail & home delivery *(limited to 30-day supply)*	Specialty drugs are always limited to a 30-day supply and require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	30% coinsurance	----------None----------
	Physician/surgeon fees	10% coinsurance	30% coinsurance	----------None----------
If you need immediate medical attention	Emergency room care	$100 copayment/ emergency room charge and 10% coinsurance for other emergency room services; deductible does not apply to emergency room visit charge	$100 copayment/ emergency room charge and 10% coinsurance for other emergency room services; deductible does not apply to emergency room visit charge	----------None----------

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Emergency medical transportation	10% coinsurance	10% coinsurance	
	Urgent care	10% coinsurance	10% coinsurance	----------None----------
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	30% coinsurance	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% coinsurance	30% coinsurance	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	No charge	10% coinsurance; deductible does not apply	All non-emergent inpatient hospital stays require prior authorization. Benefits may not be payable if you do not obtain prior authorization.
	Inpatient services	0% coinsurance	0% coinsurance	
If you are pregnant	Office visits	10% coinsurance	30% coinsurance	Cost-sharing does not apply to certain preventive services. Depending on the type of services, coinsurance 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% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	10% coinsurance	30% coinsurance	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	30% coinsurance	Coverage is limited to 40 visits per covered person/year
	Rehabilitation services	10% coinsurance	30% coinsurance	----------None----------
	Habilitation services	10% coinsurance	30% coinsurance	
	Skilled nursing care	10% coinsurance	30% coinsurance	Coverage is limited to 30 days per calendar year. All non-emergent admissions require prior authorization. Benefits may not be payable if you do not obtain prior authorization.

* For more information about limitations and exceptions, see the plan or Summary Plan Description at www.aspirushealthplan.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Signature Network Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Durable medical equipment	10% coinsurance	30% coinsurance	Prior authorization required for: • All CPAP/BiPAP purchases and rentals • Purchases over $1,000 • All other rentals as stated on our website (www.aspirushealthplan.com) Benefits may not be payable if you do not obtain prior authorization.
	Hospice services	10% coinsurance	30% 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	30% coinsurance	----------None----------
	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.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Infertility treatment
- Long Term Care
- 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 is not a complete list. Please see your plan document.)

- Chiropractic care
- Non-emergency care when traveling outside the U.S.
- 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 x61565 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 on how 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 1-866-631-5404. 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

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 1-866-631-5404 (TTY: 1-866-631-8597)

Hmong (LUS CEEV): Yog tias koj hais lus Hmoob, cov kev pub txog lus, muaj kev pab dawb rau koh. Hu rau 1-866-631-5404 (TTY: 1-866-631-8597)

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-866-631-5404 (TTY: 1-866-631-8597)

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-866-631-5404 (TTY: 1-866-631-8597)

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-866-631-5404 (TTY: 1-866-631-8597)

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	**$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	$500
Copayments	$40
Coinsurance	$1,230
What is not covered	
Limits or exclusions	$0
The total Peg would pay is	**$1,770**

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

The plan's overall deductible	**$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	$500
Copayments	$970
Coinsurance	$70
What is not covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,540**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$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	$500
Copayments	$100
Coinsurance	$110
What is not covered	
Limits or exclusions	$0
The total Mia would pay is	**$710**

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

ASPIRUS HEALTH PLAN

Non-Discrimination and Language Access Policy

Aspirus Health Plan, Inc. (Aspirus Health Plan) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan:

Provides 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)

Provides 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, call us at the phone number on the attached correspondence, your ID card, or the number listed on **AspirusHealthPlan.com**.

If you believe that Aspirus Health Plan 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:

Aspirus Health Plan
Attn: Nondiscrimination Grievance Coordinator
PO Box 1062
Minneapolis, MN 55440
Emails: G&A@AspirusHealthPlan.com

You can file a grievance in person, by mail, or by 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 ocrportal.hhs.gov/ocr/portal/lobby.jsf; by mail at U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; or by phone at 1–800–368–1019, TTY: 1–800–537–7697. Complaint forms are available at hhs.gov/ocr/office/file/index.html.

Aspirus Health Plan Language Access Policy

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-866-631-5404 (TTY: 1-866-631-8597).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بنا على رقم الهاتف 1-866-631-5404 (رقم هاتف الصم والبكم: 1-866-631-8597).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-631-5404 (ATS : 1-866-631-8597).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-866-631-5404 (TTY: 1-866-631-8597).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-866-631-5404 (TTY: 1-866-631-8597) पर कॉल करें।

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: 1-866-631-8597).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-866-631-5404 (TTY: 1-866-631-8597) 번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-866-631-5404 (TTY: 1-866-631-8597).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-631-5404 (телетайп: 1-866-631-8597).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-631-5404 (TTY: 1-866-631-8597)..

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: 1-866-631-8597)..

Traditional Chineese: 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: 1-866-631-8597).。

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: 1-866-631-8597).

Pennsylvania Dutch: Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-631-5404 (TTY: 1-866-631-8597).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ສເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-866-631-5404 (TTY: 1-866-631-8597)..