Individual Policy Change Request Form

ASPIRUS HEALTH PLAN

Subscriber Last Name	First Name	MI	Subscriber Number

A. Check and complete the changes that apply and sign below

☐ Name Change	Change From	Change To	Reason For Change
	If Married, Spouse's Name	Date of Marriage	Date of Divorce

☐ Phone Number Change	○ Home ○ Work ○ Cell	Change To
☐ Email Address Change	Change To	

☐ Address Change *Disclaimer: If you move to a different county, rates or plan offerings may be affected.*	Change applies to ○ Residence Address ○ Mailing Address	Street/Route		Apartment Number
		City	State	ZIP Code

B. Change in Coverage *(changes will be processed according to policy)*

☐ Cancel Policy	Reason for Cancellation	Requested Cancellation Date
☐ Change Policy	Plan Name (selection, metal tier, deductible shown on page 2)	Effective Date of Change
☐ Cancel Policy	Qualifying Event ☐ Birth ☐ Adoption ☐ Marriage ☐ Loss of Coverage ☐ Other: _____	Effective Date of Change
☐ Delete Dependent	Effective Date of Termination	Reason for Termination

C. Dependents

Please list family members to be added/deleted under this policy. Please attach additional form, if needed. Write name as it should appear on ID card. Dependents may not be eligible if other medical coverage is available to them through their employer.

Change	Last Name	First Name	MI	Gender	Date of Birth	Social Security #	Tobacco Use?
○ Add ○ Delete				○ M ○ F			○ Y ○ N
○ Add ○ Delete				○ M ○ F			○ Y ○ N
○ Add ○ Delete				○ M ○ F			○ Y ○ N
○ Add ○ Delete				○ M ○ F			○ Y ○ N

D. Type of Coverage and Benefit Plans

	Plan ID	Plan Name	Deductible	Coinsurance	Out-of-Pocket	Telemedicine Copay	Convenient Care Clinic copay	Office Visit Copay	Prescription Drugs Preventive, Tier 1, Tier 2, Tier 3, Specialty
HMO PLANS									
☐	86584WI0010005	**Bronze 9100 ***	$9,100	0%	$9,100	D/C	D/C	D/C	$0 preventive D/C all others
☐	86584WI0010006	**Bronze 6500 with 3 Free PCP Visits**	$6,500	20%	$8,550	D/C	D/C	First 3 PCP visits free then D/C D/C Specialist	$0 preventive D/C all others
☐	86584WI0010011	**Bronze 7500 ***	$7,500	50%	$9,000	$50	$50	$50 PCP $100 Specialist	$0 / $25 / Ded then $50 / Ded then $100 / Ded then $500
☐	86584WI0010001	**Silver 7500**	$7,500	30%	$8,400	$0	$10	$40 PCP $80 Specialist	$0 / $20 / $40 / Ded then $80 / Ded then $350
☐	86584WI0010012	**Silver 5800 ***	$5,800	40%	$8,900	$40	$40	$40 PCP $80 Specialist	$0 / $20 / $40 / Ded then $80 / Ded then $350
☐	86584WI0010007	**Gold 2800**	$2,800	30%	$6,500	$0	$10	$30 PCP $60 Specialist	$0 / $15 / $30 / $60 / $250
☐	86584WI0010015	**Gold 2000 ***	$2,000	25%	$8,700	$30	$30	$30 PCP $60 Specialist	$0 / $15 / $30 / $60 / $250
☐	86584WI0010008	**Catastrophic 9100 With 3 Free PCP Visits ****	$9,100	0%	$9,100	D/C	D/C	D/C	$0 preventive D/C all others
HMO - HSA QUALIFIED PLANS									
☐	86584WI0010009	**HDHP Bronze 6900**	$6,900	0%	$6,900	D/C	D/C	D/C	$0 preventive, D/C all others
☐	86584WI0010003	**HDHP Bronze 6000**	$6,000	30%	$6,950	D/C	D/C	D/C	$0 preventive, D/C all others
☐	86584WI0010013	**HDHP Bronze 5400**	$5,400	0%	$5,400	D/C	D/C	D/C	$0 preventive, D/C all others
POS - COPAY PLANS									
☐	86584WI0020005	**Bronze 7500**	$7,500	50%	$9,000	$50	$50	$50 PCP $100 Specialist	$0 / $25 / Ded then $50 / Ded then $100/ Ded then $500
☐	86584WI0020001	**Silver 5800 ***	$5,800	40%	$8,900	$40	$40	$40 PCP $80 Specialist	$0 / $20 / $40 / Ded then $80 / Ded then $350
POS - HSA QUALIFIED PLANS									
☐	86584WI0020003	Bronze 6000	$6,000	30%	$6,950	D/C	D/C	D/C	$0 preventive D/C all others

D/C = Deductible and Coinsurance Ded = Deductible PCP = Primary Care Practitioner HMO = Health Maintenance Plan POS = Point-of-Service Plan

* Standardized plan option
** Eligibility limited to Persons under age 30 or those with a hardship exemption from the Federally Facilitated Marketplace.

These policies do not include pediatric dental services. Pediatric dental coverage is an essential health benefit that can be purchased as a stand-alone plan through the marketplace at HealthCare.gov. Please contact your broker or HealthCare.gov (1.800.318.2596).

E. Certification

CERTIFICATION: I represent and certify all of the following: no answer or information written by myself in this application was provided by the agent or anyone else (except for information provided by other family members); such representations are true, accurate, and complete to the best of my knowledge.

Subscriber Signature	Date

You may email this form to the attention of Aspirus Individual Product Department at IndividualSales@aspirushealthplan.com, or mail to Attn: Individual Product Department, PO Box 1062, Minneapolis, MN 55440. Please call 866.631.4611 Sales Option #2 with any questions.

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 *contract*, *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: 1.866.631.5404 (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.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1.866.631.5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً . اتصل بن اعلى رقم الهاتف 1.866.631.5404(رقم هاتف الصم والبك : 711)

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

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

Hindi: _यान द_: य_द आप ि◌हंदी बोलते ह_ तो आपके ि◌लए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1.866.631.5404 (TTY: 711) 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 1.866.631.5404 (TTY: 711).

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

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 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).

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

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 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).

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).

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 1.866.631.5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1.866.631.5404 (TTY:711).