

ASPIRUS HEALTH PLAN LARGE GROUP POS PLANS

Benefit Options*

Primary Care Practitioner/Specialist

Office Visit Copay Options: \$25/\$50 • \$35/\$70

Preventive/Tier 1/Tier 2/Tier 3/Specialty

Drug Coverage Options: \$0/\$10/\$35/\$60/25% to \$250

\$0/\$15/\$45/\$80/25% to \$250 • \$0/\$20/\$50/\$100/25% to \$250

Emergency Room

Copay Options: \$300 • \$500



Bold plans include three free visits to your primary care practitioner!

Deductible		Coinsurance		Annual Out-of-Pocket Limit ¹		In-Network ² Annual Maximum Out-of-Pocket Individual/Family
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family	
\$500/\$1,000	\$1,000/\$2,000	0%	30%	\$500/\$1,000	\$10,000/\$20,000	\$8,550/\$17,100
\$500/\$1,000	\$1,000/\$2,000	20%	40%	\$6,500/\$13,000	\$13,000/\$26,000	\$8,550/\$17,100
\$1,000/\$2,000	\$2,000/\$4,000	20%	40%	\$4,000/\$8,000	\$8,000/\$16,000	\$8,550/\$17,100
\$1,000/\$2,000³	\$2,000/\$4,000	0%	30%	\$1,000/\$2,000	\$11,000/\$22,000	\$8,550/\$17,100
\$2,000/\$4,000	\$4,000/\$8,000	20%	40%	\$5,000/\$10,000	\$10,000/\$20,000	\$8,550/\$17,100
\$2,000/\$4,000	\$4,000/\$8,000	0%	30%	\$2,000/\$4,000	\$13,000/\$26,000	\$8,550/\$17,100
\$3,000/\$6,000	\$6,000/\$12,000	20%	40%	\$6,000/\$12,000	\$12,000/\$24,000	\$8,550/\$17,100
\$3,000/\$6,000	\$6,000/\$12,000	0%	30%	\$3,000/\$6,000	\$15,000/\$30,000	\$8,550/\$17,100
\$4,000/\$8,000	\$8,000/\$16,000	0%	30%	\$4,000/\$8,000	\$17,000/\$34,000	\$8,550/\$17,100
\$4,000/\$8,000	\$8,000/\$16,000	20%	40%	\$7,000/\$14,000	\$14,000/\$28,000	\$8,550/\$17,100
\$5,000/\$10,000³	\$10,000/\$20,000	0%	30%	\$5,000/\$10,000	\$19,000/\$38,000	\$8,550/\$17,100
\$5,000/\$10,000	\$10,000/\$20,000	20%	40%	\$8,000/\$16,000	\$16,000/\$32,000	\$8,550/\$17,100
\$5,500/\$11,000	\$11,000/\$22,000	0%	30%	\$5,500/\$11,000	\$15,500/\$31,000	\$8,500/\$17,100
\$5,500/\$11,000	\$11,000/\$22,000	20%	40%	\$8,000/\$16,000	\$17,000/\$34,000	\$8,550/\$17,100

*Additional benefit options may be available for experience-rated groups.

¹This annual out-of-pocket limit is for deductible and coinsurance only.

²This annual maximum out-of-pocket amount includes deductible, coinsurance, and copays for medical and pharmacy benefits. The annual maximum out-of-pocket limit only applies to in-network benefits.

³This plan allows the copay to be waived for the first three office visits with a primary care practitioner (PCP).

Common Medical Event	Services You May Need	Your cost if you use a		Notes
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care office visit	Copay	Deductible/Coinsurance	You pay a \$10 copay/visit for a MDLIVE visit
	Specialist office visit	Copay	Deductible/Coinsurance	None
	Other practitioner office visit	Copay	Deductible/Coinsurance	You pay a \$10 copay/visit for a MDLIVE visit
	Preventive care/screening	\$0	Deductible/Coinsurance	None
	Immunizations	\$0	\$0	Immunizations for travel are not covered
If you have a test in a physician's office	Diagnostic test (X-ray/blood work) in an office or outpatient department of a hospital	Coinsurance	Deductible/Coinsurance	None
	Imaging (CT/PET scans, MRIs)	Coinsurance	Deductible/Coinsurance	Prior authorization is required for PET scans, MRIs, MRAs, MRVs, and CCTAs*
If you need drugs to treat your illness or condition**	Generic drugs	Copay	Not Covered	90-day supply limit for retail; home delivery 90-day supply for 2.5x retail copay; 30-day supply for specialty drugs; drugs may require prior authorization*
	Preferred brand-name drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/Coinsurance	Deductible/Coinsurance	None
	Physician/surgeon fees	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need immediate medical attention	Emergency room visit	ER Copay	ER Copay	None
	Related emergency room services	Coinsurance		None
	Emergency medical transportation	Participating Provider Deductible/Coinsurance		Prior authorization is required for non-emergency transport*
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Physician/surgeon stay	Deductible/Coinsurance	Deductible/Coinsurance	None
If you have mental health, or substance abuse needs	Mental health/substance abuse outpatient office visits	PCP Copay	Deductible/Coinsurance	None
	Mental health/substance abuse inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Deductible/Coinsurance	None
If you are pregnant	Prenatal and postnatal care	Deductible/Coinsurance	Deductible/Coinsurance	None
	Delivery and all inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible/Coinsurance	Deductible/Coinsurance	Up to 40 visits per year
	Rehabilitative services (therapy)	PCP Copay	Deductible/Coinsurance	None
	Skilled nursing care in a licensed skilled nursing facility	Deductible/Coinsurance	Deductible/Coinsurance	Up to 30 days per confinement; prior authorization is required for an elective admission*
	Durable medical equipment	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization required* for: <ul style="list-style-type: none"> All CPAP purchases and rentals Purchases over \$1,000 All other rentals as stated on our website
	Hospice service	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for hospice services*
If your child needs dental or eye care	Routine eye exam	\$0	Deductible/Coinsurance	None
	Glasses	Not Covered	Not Covered	Not Covered
	Dental checkup	Not Covered	Not Covered	Not Covered

Preventive care services include routine exams, screenings, immunizations, and other services ranked A or B by the U.S. Preventive Services Task Force.

*If a prior authorization is required and one is not obtained, benefits may not be payable.

**Certain drug limitations, including mandatory generics, may apply. Please review the full policy.

All services are subject to terms and conditions of the policy.

Excluded Services and Other Covered Services

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy for other excluded services.)		
• Acupuncture	• Infertility treatment	• Routine foot care, unless associated with a specific medical diagnosis
• Bariatric surgery	• Long-term care	• Weight-loss programs
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing
• Eyeglasses	• Any service not medically necessary or experimental	• Work related sickness or injury
Other Covered Services (This isn't a complete list. Check your policy for other covered services and costs for these services.)		
<ul style="list-style-type: none"> • Routine eye care, limited to eye exams • Dental care, limited to accidental injury, hospitalizations for dental care and treatment of an underlying medical condition 	<ul style="list-style-type: none"> • Hearing aids, limited to the cost of one hearing aid, per ear, for each member under age 18 every three years • Chiropractic care 	

Benefit Payment Information

Benefit payments are subject to the applicable: calendar year deductible and coinsurance options you select; annual out-of-pocket limits; applicable copays; exclusions, limitations, and other policy terms and conditions.

Dependent Children, Domestic Partners

Aspirus Health Plan group plans include coverage for dependents up to age 26. (See policy for details.) Optional domestic partner benefits are also available. There may be tax consequences to employees who enroll dependents or domestic partners that do not meet the IRC § 152 definitions of dependents/spouses. Employees should consult with a tax advisor prior to enrolling for this coverage.

Premium and Renewal Terms

We determine your group's premium based on a number of factors, including your group's characteristics and the various benefit design options you select.

You submit the initial monthly premium (unless choosing to make payments using Electronic Funds Transfer), along with your completed application materials, to us. Then, you submit all subsequent premium payments to us along with a copy of the premium notice (unless choosing to make payments using Electronic Funds Transfer). For coverage to continue, we need to receive the premium as required by the policy. A participant's coverage depends on his or her eligibility under the terms and conditions of your Aspirus Health Plan group policy.

Grievance Procedure

If a participant has a question or concern that can't be resolved by our Member Services staff, he or she can file a written grievance detailing the reason(s) for disagreeing with our benefit or claim payment decision.

At Aspirus Health Plan, we define a "grievance" as meaning any dissatisfaction with us or our administration of your health benefit plan that you express to us in writing.

Written requests and copies of any supporting information (such as letters, medical records, clinical reports, or other relevant documents that show the medical reason(s) why we should change our decision) should be sent to:

Aspirus Health Plan
 Attention: Grievance Coordinator
 PO Box 1062
 Minneapolis, MN 55440
 Fax: 763-847-4010

ASPIRUS HEALTH PLAN LARGE GROUP POS PLANS HSA-QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (HDHP)

Benefit Options*

HSA-Qualified HDHP Non-Embedded Deductible

Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
\$1,400/\$2,800 ¹	\$2,800/\$5,600	0%	20%	\$1,400/\$2,800	\$4,800/\$9,600
\$1,400/\$2,800 ²	\$2,800/\$5,600	20%	40%	\$4,500/\$9,000	\$4,800/\$9,600
\$2,000/\$4,000 ¹	\$4,000/\$8,000	0%	20%	\$2,000/\$4,000	\$6,000/\$12,000
\$2,000/\$4,000 ²	\$4,000/\$8,000	20%	40%	\$5,000/\$10,000	\$6,000/\$12,000

These plans feature non-embedded deductibles; If an employee has family coverage, the family deductibles must be satisfied before these plans will pay benefits. One person can satisfy the family deductible.

Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. HSA is administered and/or maintained by a participating financial institution. Aspirus Health Plan does not operate or administer HSAs.

Each year, your plan's deductible will be automatically adjusted to reflect federal guidelines and remain HSA-qualified.

¹This plan features a non-embedded annual out-of-pocket limit. If an employee has family coverage, the family out-of-pocket must be satisfied before this plan will pay 100% of covered benefits. One person can satisfy the family annual out-of-pocket.

²This plan features an embedded annual out-of-pocket limit. If an employee has family coverage, the individual annual out-of-pocket must be satisfied before this plan will pay 100% of covered benefits for that family member.

HSA-Qualified HDHP-Embedded Deductible

Deductible		Coinsurance		Annual Out-of-Pocket Limit	
In-Network Individual/Family	Out-of-Network Individual/Family	In-Network	Out-of-Network	In-Network Individual/Family	Out-of-Network Individual/Family
\$3,000/\$6,000	\$6,000/\$12,000	0%	20%	\$3,000/\$6,000	\$8,000/\$16,000
\$3,000/\$6,000	\$6,000/\$12,000	20%	40%	\$6,000/\$12,000	\$8,000/\$16,000
\$4,000/\$8,000	\$6,000/\$12,000	0%	20%	\$4,000/\$8,000	\$8,000/\$16,000
\$4,000/\$8,000	\$6,000/\$12,000	20%	40%	\$7,000/\$14,000	\$8,000/\$16,000
\$5,000/\$10,000	\$7,500/\$15,000	0%	20%	\$5,000/\$10,000	\$9,500/\$19,000
\$5,000/\$10,000	\$7,500/\$15,000	20%	40%	\$7,000/\$14,000	\$9,500/\$19,000
\$6,000/\$12,000	\$9,000/\$18,000	0%	20%	\$6,000/\$12,000	\$11,000/\$22,000
\$7,000/\$14,000	\$10,500/\$21,000	0%	20%	\$7,000/\$14,000	\$12,500/\$25,000

These plans feature embedded deductibles. Once a family member reaches the individual deductible amount, these plans will begin to pay benefits for him or her only. Once the family deductible amount is reached, these plans will begin to pay benefits for each member of the family.

These plans feature embedded annual out-of-pocket limits. If an employee has family coverage, the individual out-of-pocket must be satisfied before this plan will pay 100% of covered benefits for that family member. Deductibles and out-of-pocket maximums apply annually. In-network and out-of-network deductible and coinsurance amounts must be satisfied separately. HSA is administered and/or maintained by a participating financial institution. Aspirus Health Plan does not operate or administer HSAs.

*Additional benefit options may be available for experience-rated groups.

Common Medical Event	Services You May Need	Your cost if you use a		Notes
		Participating Provider	Non-Participating Provider	
If you visit a health care provider's office or clinic	Primary care office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a MDLIVE provider
	Specialist office visit	Deductible/Coinsurance	Deductible/Coinsurance	None
	Other practitioner office visit	Deductible/Coinsurance	Deductible/Coinsurance	Includes telehealth visits with a MDLIVE provider
	Preventive care/screening	\$0	Deductible/Coinsurance	None
	Immunizations	\$0	\$0	Immunizations for travel are not covered
If you have a test in a physician's office	Diagnostic test (X-ray, blood work)	Deductible/Coinsurance	Deductible/Coinsurance	None
	Imaging (CT/PET scans, MRIs)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for PET scans, MRIs, MRAs, MRVs, and CCTAs*
If you need drugs to treat your illness or condition**	Generic drugs	Deductible/Coinsurance	Not Covered	90-day supply limit for retail; home delivery 90-day supply for 2.5x retail copay; 30-day supply for specialty drugs; drugs may require prior authorization*
	Preferred brand-name drugs			
	Non-preferred brand drugs			
	Specialty drugs			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	Deductible/Coinsurance	Deductible/Coinsurance	None
	Physician/surgeon fees	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need immediate medical attention	Emergency room visit	Participating Deductible/Coinsurance		None
	Emergency medical transportation	Participating Deductible/Coinsurance		Prior authorization is required for non-emergency transport*
If you have a hospital stay	Facility fee (e.g., hospital room)	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Physician/surgeon stay	Deductible/Coinsurance	Deductible/Coinsurance	None
If you have mental health, or substance abuse needs	Mental health/substance abuse outpatient office visits	Deductible/Coinsurance	Deductible/Coinsurance	None
	Mental health/substance abuse inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for elective inpatient stays*
	Mental health/substance abuse transitional treatment	Deductible/Coinsurance	Deductible/Coinsurance	None
If you are pregnant	Prenatal and postnatal care	Deductible/Coinsurance	Deductible/Coinsurance	None
	Delivery and all inpatient services	Deductible/Coinsurance	Deductible/Coinsurance	None
If you need help recovering or have other special health needs	Home health care	Deductible/Coinsurance	Deductible/Coinsurance	Up to 40 visits per year
	Rehabilitative services (therapy)	Deductible/Coinsurance	Deductible/Coinsurance	None
	Skilled nursing care in a licensed skilled nursing facility	Deductible/Coinsurance	Deductible/Coinsurance	Up to 30 days per confinement; prior authorization is required for an elective admission*
	Durable medical equipment	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization required* for: <ul style="list-style-type: none"> All CPAP purchases and rentals Purchases over \$1,000 All other rentals as stated on our website
	Hospice service	Deductible/Coinsurance	Deductible/Coinsurance	Prior authorization is required for hospice services*
If your child needs dental or eye care	Routine eye exam	\$0	Deductible/Coinsurance	None
	Glasses	Not Covered	Not Covered	Not Covered
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• Bariatric surgery	• Long-term care	• Weight-loss programs
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Private-duty nursing
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• Routine eye care, limited to eye exams	• Hearing aids, limited to the cost of one hearing aid, per ear, for each member under age 18 every three years	
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Aspirus Health Plan
Attention: Grievance Coordinator
PO Box 1062
Minneapolis, MN 55440
Fax: 763-847-4010

IMPORTANT: This summary of benefits provides only a general description of benefits, limitations, and exclusions. You can find a detailed description of coverage in the applicable policy issued to you. Coverage is subject to all the terms and conditions of the policy and any endorsements. If there's ever a discrepancy between the policy and this brochure, the policy has final authority.

Contact us for more information

AspirusHealthPlan.com
715.843.1393

