Assurant Small Group Select Platinum: John Alden Life Ins. Co.

Coverage Period: 01/01/2015 – 12/31/2015

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Employee | **Plan Type:** PPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at http://www.assuranthealth.com/corp/ah/HealthPlans/small-business-health-insurance.htm or by calling **1-800-328-4316**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For participating providers **$750**; For non-participating providers **$2,250**. No charge, including **deductible**, for preventive care services noted in the Limitations and Exceptions section. First dollar benefits, copays and non-participating coinsurance don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. For participating providers **$1,000**; for non-participating providers **$3,000**.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	First Dollar X-ray & Lab, premiums, balance-billed charges, penalty for not obtaining pre-authorization, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.aetna.com/asa.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred** or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-328-4316** or visit us at http://www.assuranthealth.com/corp/ah/AHHome.htm.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call **1-800-328-4316** to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit	40% coinsurance	---none---
	Specialist visit	$50 copay/visit	40% coinsurance	
	Other practitioner office visit	$35 copay/visit	40% coinsurance	
	Preventive care/screening/immunization	20% coinsurance	40% coinsurance	No charge for participating services mandated by federal law. No charge for prenatal care services and child health supervision services. No charge for covered contraceptive drugs and devices and other prescriptions that fall under the rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force ("USPSTF") dispensed by participating providers.
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first $500 in outpatient benefits. Then deductible and 20% coinsurance.	No charge for the first $500 in outpatient benefits. Then deductible and 40% coinsurance.	---none---
	Imaging (CT/PET scans, MRIs)			
If you need drugs to treat your illness or condition	Generic drugs	$10 copay/31-day supply $30 copay/93-day supply	$10 copay/31-day supply $30 copay/93-day supply	---none---

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
More information about **prescription drug coverage** is at 1-800-545-9917. For information about Specialty drugs, call 1-800-328-4316.	Preferred brand drugs	$30 copay/31-day supply $90 copay/93-day supply	$30 copay/31-day supply $90 copay/93-day supply	When a generic is available you pay the difference between the Brand and Generic contracted rate.
	Non-preferred brand drugs	$55 copay/31-day supply $165 copay/93-day supply	$55 copay/31-day supply $165 copay/93-day supply	
	Specialty drugs	20% coinsurance	Not covered.	To receive the participating provider benefit, you must obtain specialty drugs from a specialty pharmacy provider as designated by us. Call 800-328-4316 for further information. Specialty drugs obtained from a non-designated specialty pharmacy provider will not be covered. Authorization is required for non-designated providers. Benefits will not be paid for any specialty drugs that are not authorized by the Medical Review Manager.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	---none---
	Physician/surgeon fees	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room services	20% coinsurance	20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance	20% coinsurance	To the nearest Acute Medical Facility that can treat the sickness or injury.
	Urgent care	20% coinsurance	40% coinsurance	---none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Authorization required for non-participating provider transplants. Benefits will not be paid for any transplants that are not authorized by the Medical Review Manager.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	---none---
If you have mental	Mental/Behavioral health outpatient services	$35 copay/visit for	40% coinsurance	Copay will apply to visits for diagnosis,

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
health, behavioral health, or substance abuse needs		Primary Care Provider; $50 copay/visit for Specialist		evaluation and therapy. Coverage for other services are subject to deductible and coinsurance.
	Mental/Behavioral health inpatient services	20% coinsurance	40% coinsurance	---none---
	Substance use disorder outpatient services	$35 copay/visit for Primary Care Provider; $50 copay/visit for Specialist	40% coinsurance	Copay will apply to visits for diagnosis, evaluation and therapy. Coverage for other services are subject to deductible and coinsurance.
	Substance use disorder inpatient services	20% coinsurance	40% coinsurance	---none---
If you are pregnant	Prenatal and postnatal care	20% coinsurance	40% coinsurance	Prenatal Care is paid at 100%. Coverage includes 1 post-partum home visit after each delivery.
	Delivery and all inpatient services	20% coinsurance	40% coinsurance	---none---
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	Limited to 120 visits each year.
	Rehabilitation services	20% coinsurance	40% coinsurance	Pre-authorization required if the course of treatment will exceed 12 visits or last longer than 30 days. Limited to 20 visits per year for Physical and Occupational Therapy. Limited to 20 visits per year for Speech Therapy. Adjustments and manipulations are limited to 20 visits per year. Ventilator-dependent patient care services rendered by a private-duty nurse or personal care assistant are limited to 120 hours per lifetime.
	Habilitation services	20% coinsurance	40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	Coverage is limited to 120 days per admission per year for Subacute Rehabilitation Facility and/or Skilled Nursing Care.
	Durable medical equipment	20% coinsurance	40% coinsurance	Pre-authorization required with a purchase price in excess of $500.

Common Medical Event	Services You May Need	Your Cost If You Use a Participating Provider	Your Cost If You Use a Non-participating Provider	Limitations & Exceptions
				Replacement, repair, modification, duplication or enhancement of other durable medical equipment may be authorized, but is generally excluded. Coverage for hearing aids are limited to 1 per ear every 3 years for 18 or younger. Scalp hair prostheses worn for hair loss as a result of alopecia areata is limited to 1 per year.
	Hospice service	20% coinsurance	40% coinsurance	---none---
If your child needs dental or eye care	Eye exam	20% coinsurance	40% coinsurance	Limited to 1 visit per year.
	Glasses	20% coinsurance	40% coinsurance	Limited to 1 pair of glasses or 1 year supply of contact lenses in the Pediatric Eyewear Collection per year.
	Dental check-up	No Charge.	No Charge.	Limited to 1 check-up every 6 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery (unless reconstructive)
- Dental care (Adult)
- Hearing aids
- Infertility treatment
- Long-term care
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care
- Hearing aids (for children)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 800-328-4316. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cms.gov/cciio/index.html.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance.** For questions about your rights, this notice, or assistance, you can contact: Department of Labor's Employee Benefits Security Administration, Phone: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Minnesota Department of Commerce, Consumer Protection and Education Division, 85 7th Place East, Suite 500, St. Paul, MN 55101-2198, Phone: 651-539-1600 or 1-800-657-3602 (MN only), FAX: 651-539-0105, Email: consumer.protection@state.mn.us, or visit http://mn.gov/commerce/insurance/.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-328-4316.

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

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,540
- **Patient pays** $1,000

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$800
Copays	$0
Coinsurance	$200
Limits or exclusions	$0
Total	**$1,000**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,400
- **Patient pays** $1,000

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$500
Copays	$500
Coinsurance	$0
Limits or exclusions	$0
Total	**$1,000**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.