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 www.assuranthealth.com or by calling 1-800-328-4316.

Important Questions	Answers	Why this Matters:
What is the overall deductible (DED)?	For participating (PAR) providers $750; For non-participating (NON-PAR) providers $2,250. Does not apply to certain preventive care. First dollar benefits, Copays and Out-of-network (OON) coinsurance (COINS) don't count toward the DED.	You must pay all the costs up to the **DED** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **DED** 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 **DED**.
Are there other deductibles (DED) for specific services?	No. There are no other specific **DEDs**.	You don't have to meet **DEDs** 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 (OOP) limit on my expenses?	Yes. For PAR providers $1,000; for NON-PAR providers $3,000.	The **OOP 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 (OOP) limit?	First Dollar Diagnostic Xray & Lab benefit, premiums, balance-billed charges, penalties for not obtaining pre-authorization (pre-AUTH) for services and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **OOP 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 (PAR) providers**, see **www.aetna.com/asa**. For emergencies, benefits are paid at the participating provider level.	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 OON **provider** for some services. Plans use the terms 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	Written/verbal approval is not required for a	You can see the **specialist** you choose without permission from

see a specialist?	**specialist**.	this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 7. See your policy or plan document for additional information about **excluded services.**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance (COINS)** 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 **COINS** payment of 20% would be $200. This may change if you haven't met your **DED.**
- 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 PAR **providers** by charging you lower **DEDs**, **copayments** and **COINS** amounts.

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Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider*	Your Cost If You Use an Out-of-network 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% COINS.	----none---
	Specialist visit	$50 Copay/visit.	40% COINS	
	Other practitioner office visit	$35 Copay/visit.	40% COINS	
	Preventive care/screening/immunization	No Charge.	40% COINS	No charge for PAR services mandated by federal law.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider*	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	No charge for the first $500 in outpatient benefits. Then DED and 20% COINS.	No charge for the first $500 in outpatient benefits. Then DED and 40% COINS.	First dollar benefit does not apply to the Total OOP.
	Imaging (CT/PET scans, MRIs)	No charge for the first $500 in outpatient benefits. Then DED and 20% COINS.	No charge for the first $500 in outpatient benefits. Then DED and 40% COINS.	
If you need drugs to treat your illness or condition More information about **prescription (RX) drug coverage** is at caremark.com For information about **Specialty drugs**, call 1-800-328-4316.	Generic drugs	$10/RX	$10/RX	Copay/30 day supply. $30/RX – 90 day supply.
	Preferred brand drugs	$30/RX	$30/RX	Copay/30 day supply. $90/RX - 90 day supply. When a generic is available pay the difference between the Brand and Generic contracted rate.
	Non-preferred brand drugs	$55/RX	$55/RX	Copay/30 day supply. $165/RX - 90 day supply. When a generic is available pay the difference between the Brand and Generic contracted rate.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider*	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Specialty drugs	20% COINS	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 (AUTH) is required. 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% COINS.	40% COINS	Pre-AUTH required.
	Physician/surgeon fees	20% COINS.	40% COINS.	Pre-AUTH required.
If you need immediate medical attention	Emergency room services	20% COINS.	40% COINS.	----none---
	Emergency medical transportation	20% COINS.	40% COINS.	To the nearest Acute Medical Facility that can treat the sickness or injury.
	Urgent care	20% COINS.	40% COINS.	----none---
If you have a hospital stay	Facility fee (e.g., hospital room)	20% COINS.	40% COINS.	Pre-AUTH required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider*	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Physician/surgeon fee	20% COINS.	40% COINS.	Pre-AUTH required.
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$35 copay/visit for Primary Care Provider; $50 copay/visit for Specialist	40% COINS.	Copay will apply to visits for diagnosis, evaluation and therapy. Coverage for other services are subject to DED and COINS. Pre-AUTH required.
	Mental/Behavioral health inpatient services	20% COINS.	40% COINS.	Pre-AUTH required.
	Substance use disorder outpatient services	$35 copay/visit for Primary Care Provider; $50 copay/visit for Specialist	40% COINS.	Copay will apply to visits for diagnosis, evaluation and therapy. Coverage for other services are subject to DED and COINS. Pre-AUTH required
	Substance use disorder inpatient services	20% COINS.	40% COINS.	Pre-AUTH required.
If you are pregnant	**Prenatal** and postnatal care	20% COINS.	40% COINS.	**Prenatal Care is paid at 100% when a PAR provider is used.** Coverage includes 1 post-partum home visit after each delivery.
	Delivery and all inpatient services	20% COINS.	40% COINS.	Pre-AUTH required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider*	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% COINS.	40% COINS.	Limited to 60 visits per person each calendar year. Pre-AUTH required.
	Rehabilitation services	20% COINS.	40% COINS.	Limited to 45 visits per person per calendar year combined for Physical Therapy, Occupational Therapy and Speech Therapy. Coverage for adjustments and manipulations are limited to 20 visits per person per calendar year. Cardiac rehabilitation is limited to 18 visits per person per calendar year. Pulmonary rehabilitation is limited to 18 visits per person per year. Pre-AUTH required.
	Habilitation services	20% COINS.	40% COINS.	Limited to 45 visits per person per calendar year combined for Physical Therapy, Occupational Therapy and Speech Therapy. Coverage for adjustments and manipulations are limited to 20 visits per person per calendar year. Cardiac rehabilitation is limited to 18 visits per person per calendar year. Pulmonary rehabilitation is limited to 18 visits per person per year. Pre-AUTH required.

Common Medical Event	Services You May Need	Your Cost If You Use an In-network Provider*	Your Cost If You Use an Out-of-network Provider	Limitations & Exceptions
	Skilled nursing care	20% COINS.	40% COINS.	Coverage is limited to 60 days/person per calendar year for Subacute Rehabilitation Facility and/or Skilled Nursing Care. Pre-AUTH required.
	Durable medical equipment (DME)	20% COINS.	40% COINS.	Replacement, repair, modification, duplication or enhancement of other DME is not covered. Pre-AUTH required.
	Hospice service	20% COINS.	40% COINS.	Pre-AUTH required.
If your child needs dental or eye care	Eye exam	20% COINS.	40% COINS.	Limited to 1 visit per child per year for children up to age 19.
	Glasses	20% COINS.	40% COINS.	Limited to a maximum of 1 pair of glasses (Standard Frames) per Calendar Year or 1 year supply of standard contact lenses per child per year for children up to age 19.
	Dental check-up	20% COINS.	40% COINS.	Benefits for children up to age 19. Limited to 1 check-up every 6 months. Limited to $3,000 for out-of-network pediatric dental services.

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.)

- Acupuncture
- Cosmetic surgery
- Infertility treatment
- Routine eye care (Adult)
- Bariatric surgery
- Dental care (Adult)
- Long term care
- Routine foot care

Questions: Call 1-800-328-4316 or visit us at www.assuranthealth.com.
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://cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-800-328-4316 to request a copy.

• Hearing aids	• Private-duty nursing	• 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.)	
• Chiropractic care	• Non-emergency care when travelling outside the U.S

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 1-800-328-4316. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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:
· Nebraska Department of Insurance, Consumer Affairs Division, 941 "O" Street, Suite 400, PO Box 82089, Lincoln, NE 68501-2089, Consumer Hotline: 1-877-564-7323, FAX: 402-471-6559, TDD 1-800-833-7352, or visit www.doi.ne.gov/.

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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **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	$750
Copays	$20
Coinsurance	$230
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	$460
Copays	$540
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.