**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/corp/ah/HealthPlans/major-medical.htm or by calling **1-800-553-7654**.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For network providers **$2,000**; for non-network providers **$2,000**. Does not apply to mandated preventive care. First dollar benefits, copays and non-network provider 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 network providers **$3,250**; for non-network providers **$27,000**. | 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 benefits, premium, balanced-billed charges, penalties for not obtaining pre-authorization for services, 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 network providers, see www.preferredone.com or call **1-800-451-9597**. | If you use a 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 terms in-network, **preferred** or participating to refer to **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 4. See your policy or plan document for additional information about **excluded services**. |

**Questions:** Call **1-800-553-7654** 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 www.cms.gov/CCIIO/Resources/Files/Downloads/uniform-glossary-final.pdf or call **1-800-553-7654** 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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $20 copay/visit. | 70% coinsurance | ---none--- |
| | Specialist visit | $20 copay/visit. | 70% coinsurance | |
| | Other practitioner office visit | $20 copay/visit. | 70% coinsurance | |
| | Preventive care/screening/immunization | 50% coinsurance | 70% coinsurance | No charge for network provider 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 network providers. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 50% coinsurance | 70% coinsurance | No charge for the first $100 of outpatient lab/x-ray benefits combined. Then deductible and coinsurance. |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | 70% coinsurance | |
| **If you need drugs to treat your illness or condition** | Generic drugs | $10 copay/31-day supply<br>$30 copay/93-day supply | $10 copay/31-day supply<br>$30 copay/93-day supply | ---none--- |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| More information about **prescription drug coverage** is at 1-800-545-9917.<br><br>For information about Specialty drugs, call 800-553-7654. | Brand drugs | $15 copay/31-day supply<br>$45 copay/93-day supply | $15 copay/31-day supply<br>$45 copay/93-day supply | When a generic is available you pay the difference between the Brand and Generic contracted rate. |
| | Specialty drugs | 50% coinsurance | 70% coinsurance | Most injections and intravenous drugs are covered under the deductible and coinsurance. |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 50% coinsurance | 70% coinsurance | Benefits for secondary surgical procedures performed in the same operative session will be determined by first reducing the covered charge by 50%. |
| | Physician/surgeon fees | 50% coinsurance | 70% coinsurance | Assistant surgeon's services are covered up to 20% of the covered charges for the surgery, or non-physician surgical assistants services are covered up to 5% of the covered charges for the surgery. |
| **If you need immediate medical attention** | Emergency room services | $50 copay, then deductible and 50% coinsurance. | $50 copay, then deductible and 50% coinsurance. | Copay waived if admitted to the hospital for inpatient stay. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | To the nearest Acute Medical Facility that can treat the sickness or injury. |
| | Urgent care | 50% coinsurance | 70% coinsurance | ---none--- |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance | 70% coinsurance | Authorization required for non-network provider transplants. Benefits will be reduced by 25% (up to $250) for any transplants that are not authorized by the Medical Review Manager. |
| | Physician/surgeon fee | 50% coinsurance | 70% coinsurance | ---none--- |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | $20 copay/visit. | 70% coinsurance | Copay will apply to visits for diagnosis, evaluation and therapy. Coverage for other services are subject to deductible and coinsurance. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Mental/Behavioral health inpatient services | 50% coinsurance | 70% coinsurance | ---none--- |
| | Substance use disorder outpatient services | $20 copay/visit. | 70% 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 | 50% coinsurance | 70% coinsurance | ---none--- |
| **If you are pregnant** | Prenatal and postnatal care | 50% coinsurance | 70% coinsurance | Coverage includes 1 post-partum home visit after each delivery. No charge for prenatal care or home uterine monitoring and home drug therapy for treatment of pre-term labor when medically necessary. |
| | Delivery and all inpatient services | 50% coinsurance | 70% coinsurance | ---none--- |
| **If you need help recovering or have other special health needs** | Home health care | No charge. | No charge. | Limited to 120 visits per year. |
| | Rehabilitation services | 50% coinsurance | 70% coinsurance | 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. No charge for inpatient rehabilitation services. |
| | Habilitation services | 50% coinsurance | 70% coinsurance | 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. |

| Common Medical Event | Services You May Need | Your Cost If You Use a Network Provider | Your Cost If You Use a Non-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| | Skilled nursing care | No charge. | No charge. | Coverage is limited to 120 days per admission per year for Subacute Rehabilitation Facility and/or Skilled Nursing Care. |
| | Durable medical equipment | 50% coinsurance | 70% coinsurance | Replacement, repair, modification, duplication or enhancement may be authorized, but is generally excluded. Coverage for hearing aids are limited to 1 per ear every 3 years for dependents age 18 or younger. Scalp hair prostheses worn for hair loss as a result of alopecia areata is limited to 1 per year. |
| | Hospice service | No charge. | No charge. | ---none--- |
| **If your child needs dental or eye care** | Eye exam | 50% coinsurance | 70% coinsurance | Limited to 1 visit per year. |
| | Glasses | 50% coinsurance | 70% coinsurance | Limited to 1 pair of glasses or 1 year supply of contact lenses 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 (limited to countries without U.S. travel warnings).
- Private-duty nursing

## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-553-7654. You may also contact your state insurance department at 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/.

## 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: 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.**

## Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-553-7654.

*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** $4,240
- **Patient pays** $3,300

**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 | $2,000 |
| Copays | $0 |
| Coinsurance | $1,300 |
| Limits or exclusions | $0 |
| **Total** | **$3,300** |

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,200
- **Patient pays** $2,200

**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 | $1,700 |
| Copays | $500 |
| Coinsurance | $0 |
| Limits or exclusions | $0 |
| **Total** | **$2,200** |

# 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.