



**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](http://www.assuranthealth.com/corp/ah/HealthPlans/major-medical.htm) or by calling 1-800-553-7654.

Important Questions	Answers	Why this Matters:
<b>What is the overall deductible?</b>	For participating providers <b>\$2,000</b> person/ <b>\$4,000</b> family; for non-participating providers <b>\$6,000</b> person/ <b>\$12,000</b> family. Does not apply to prescription drugs or mandated preventive care. First dollar benefits, Copays and non-participating provider coinsurance don't count toward the <b>deductible</b> .	You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b> .
<b>Are there other deductibles for specific services?</b>	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
<b>Is there an out-of-pocket limit on my expenses?</b>	Yes. For participating providers <b>\$6,350</b> person/ <b>\$12,700</b> family; for non-participating providers <b>\$19,050</b> person/ <b>\$38,100</b> family.	The <b>out-of-pocket limit</b> 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.
<b>What is not included in the out-of-pocket limit?</b>	Premium, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <b>out-of-pocket limit</b> .
<b>Is there an overall annual limit on what the plan pays?</b>	No.	The chart starting on page 2 describes any limits on what the plan will pay for <i>specific</i> covered services, such as office visits.
<b>Does this plan use a network of providers?</b>	Yes. For a list of participating providers, see <a href="http://www.assuranthealth.com/networksavings3">www.assuranthealth.com/networksavings3</a> .	If you use an in-network doctor or other health care <b>provider</b> , 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 <b>provider</b> for some services. Plans use the terms in-network, <b>preferred</b> or participating to refer to <b>providers</b> in their <b>network</b> . See the chart starting on page 2 for how this plan pays different kinds of <b>providers</b> .
<b>Do I need a referral to see a specialist?</b>	No. You don't need a referral to see a specialist.	You can see the <b>specialist</b> you choose without permission from this plan.
<b>Are there services this plan doesn't cover?</b>	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 <b>excluded services</b> .

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- **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	\$30 copay/visit.	50% coinsurance	Limited to 10 visits combined per year per person. Additional visits subject to plan deductible and coinsurance.
	Specialist visit	\$30 copay/visit.	50% coinsurance	
	Other practitioner office visit	\$30 copay/visit.	50% coinsurance	
	Preventive care/screening/immunization	50% coinsurance	50% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	50% coinsurance	50% coinsurance	---none---
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	
If you need drugs to treat your illness or condition	Generic drugs	\$15 copay/30-day supply \$45 copay/90-day supply	\$15 copay/30-day supply \$45 copay/90-day supply	---none---
	Preferred brand drugs	\$35 copay/30-day supply \$105 copay/90-day supply	\$35 copay/30-day supply \$105 copay/90-day supply	
	Non-preferred brand drugs	\$60 copay/30-day supply \$180 copay/90-day supply	\$60 copay/30-day supply \$180 copay/90-day supply	
More information about <b>prescription drug coverage</b> is at 800-545-9917.				When a generic is available pay the difference between the Brand and Generic contracted rate.
For information about Specialty drugs, call 800-553-7654.	Specialty drugs	50% coinsurance	Not covered.	To receive the participating provider benefit, you must obtain specialty drugs from a specialty pharmacy provider as designated by us. Call 800-553-7654 for further information. Specialty drugs obtained from a non-designated provider will not be covered. Authorization required for

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
				benefits to be covered.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	---none---
	Physician/surgeon fees	50% coinsurance	50% coinsurance	---none---
<b>If you need immediate medical attention</b>	Emergency room services	50% coinsurance	50% coinsurance	---none---
	Emergency medical transportation	50% coinsurance	50% coinsurance	To the nearest hospital that can treat the sickness or injury.
	Urgent care	50% coinsurance	50% coinsurance	---none---
<b>If you have a hospital stay</b>	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	---none---
	Physician/surgeon fee	50% coinsurance	50% coinsurance	---none---
<b>If you have mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$30 copay/visit.	50% coinsurance	Limited to 10 for all office visits combined per year per person. Copay will apply to visits for diagnosis, evaluation and therapy. Office visits beyond the 10 visit limit and other services are subject to deductible and coinsurance.
	Mental/Behavioral health inpatient services	50% coinsurance	50% coinsurance	---none---
	Substance use disorder outpatient services	\$30 copay/visit.	50% coinsurance	Limited to 10 for all office visits combined per year per person. Copay will apply to visits for diagnosis, evaluation and therapy. Office visits beyond the 10 visit limit and other services are subject to deductible and coinsurance.
	Substance use disorder inpatient services	50% coinsurance	50% coinsurance	---none---
<b>If you are pregnant</b>	Prenatal and postnatal care	50% coinsurance	50% coinsurance	Prenatal care is paid at 100% when a participating provider is used.
	Delivery and all inpatient services	50% coinsurance	50% coinsurance	---none---
	Home health care	50% coinsurance	50% coinsurance	Limited to 100 visits per year. Private duty nursing is limited to 100 visits per year. Intravenous injectable parenteral drug therapy is not subject to these maximum benefits.

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
<p><b>If you need help recovering or have other special health needs</b></p>	Rehabilitation services	50% coinsurance	50% coinsurance	<p>Limited to 20 visits per year each for Physical Therapy, Occupational Therapy and Speech Therapy. Adjustments and manipulations are limited to 12 visits per year. Cardiac rehabilitation is limited to 36 visits per year. Pulmonary rehabilitation is limited to 20 visits per year. Inpatient rehabilitation is limited to 60 days per year. Private duty nursing is limited to 100 visits per year.</p>
	Habilitation services	50% coinsurance	50% coinsurance	<p>Limited to 20 visits per year each for Physical Therapy, Occupational Therapy and Speech Therapy. Limited to 20 visits per year each for Occupational Therapy and Speech Therapy for treatment of autism spectrum disorders. Adjustments and manipulations are limited to 12 visits per year. Cardiac rehabilitation is limited to 36 visits per year. Pulmonary rehabilitation is limited to 20 visits per year. Inpatient rehabilitation is limited to 60 days per year. Private duty nursing is limited to 100 visits per year. Clinical therapeutic intervention for the treatment of autism spectrum disorders is limited to 20 hours per week.</p>
	Skilled nursing care	50% coinsurance	50% coinsurance	<p>Limited to 90 days per year for Subacute Rehabilitation Facility and/or Skilled Nursing Care.</p>
	Durable medical equipment	50% coinsurance	50% coinsurance	<p>Replacement, repair, modification, duplication or enhancement may be authorized, but is generally excluded. Wigs are subject to a maximum benefit of 1 wig per year following cancer treatment Surgical bras following a mastectomy are limited to 4 per year.</p>
	Hospice service	50% coinsurance	50% coinsurance	<p>---none---</p>

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 your child needs dental or eye care	Eye exam	50% coinsurance	50% coinsurance	Limited to 1 visit per year.
	Glasses	50% coinsurance	50% 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 <u>excluded services.</u> )		
<ul style="list-style-type: none"> <li>Acupuncture (except when authorized)</li> <li>Bariatric surgery</li> <li>Cosmetic surgery</li> </ul>	<ul style="list-style-type: none"> <li>Dental care (Adult)</li> <li>Hearing aids</li> <li>Infertility treatment</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>

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.)		
<ul style="list-style-type: none"> <li>Chiropractic care</li> </ul>	<ul style="list-style-type: none"> <li>Non-emergency care when traveling outside the U.S. (limited to countries without travel warnings)</li> </ul>	<ul style="list-style-type: none"> <li>Private-duty nursing</li> <li>Routine eye care (Adult)</li> </ul>

### 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 Ohio Department of Insurance, Consumer Services Division, 50 W. Town St., Suite 300, Columbus, OH 43215, Consumer Services, Phone: 1-800-686-1526, or visit [www.insurance.ohio.gov/Pages/default.aspx](http://www.insurance.ohio.gov/Pages/default.aspx).

### 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: Ohio Department of Insurance, Consumer Services Division, 50 W. Town St., Suite 300, Columbus, OH 43215, Phone: 1-800-686-1526, or visit [www.insurance.ohio.gov/Pages/default.aspx](http://www.insurance.ohio.gov/Pages/default.aspx).

### 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.**

*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.

<b>Having a baby</b> (normal delivery)	
<ul style="list-style-type: none"> <li>■ Amount owed to providers: \$7,540</li> <li>■ Plan pays \$2,810</li> <li>■ Patient pays \$4,730</li> </ul>	
<b>Sample care costs:</b>	
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
<b>Total</b>	<b>\$7,540</b>
<b>Patient pays:</b>	
Deductibles	\$2,000
Copays	\$30
Coinsurance	\$2,700
Limits or exclusions	\$0
<b>Total</b>	<b>\$4,730</b>

<b>Managing type 2 diabetes</b> (routine maintenance of a well-controlled condition)	
<ul style="list-style-type: none"> <li>■ Amount owed to providers: \$5,400</li> <li>■ Plan pays \$2,900</li> <li>■ Patient pays \$2,500</li> </ul>	
<b>Sample care costs:</b>	
Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
<b>Total</b>	<b>\$5,400</b>
<b>Patient pays:</b>	
Deductibles	\$1,800
Copays	\$700
Coinsurance	\$0
Limits or exclusions	\$0
<b>Total</b>	<b>\$2,500</b>

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## 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.

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