



Group Health Plan Notices 2023

Annual Required Legal Notices and Disclosures for Plan Participants

Medicare Part D Notice

Important Notice About Your Prescription Drug Coverage and Medicare

Individual CREDITABLE Coverage Disclosure

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Your employer has determined that the prescription drug coverage offered is expected to pay, on average, as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When can you join a Medicare drug plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare prescription drug plan.

What happens to your current coverage if you decide to join a Medicare prescription drug plan?

Individuals who are eligible for Medicare should compare their current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in their area. If you are eligible for Medicare and do decide to enroll in a Medicare prescription drug plan and drop your employer's group health plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact Human resources for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Your medical benefits brochure contains a description of your current prescription drug benefits.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with your employer and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later. If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For more information about this notice or your current prescription drug coverage...

Contact your Human Resources Department for further information NOTE: You will receive this notice annually, before the next period you can join a Medicare prescription drug plan, and if this coverage through your employer changes. You also may request a copy of this notice at any time.

For more information about your options under Medicare prescription drug coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit the Social Security Administration (SSA) online at www.socialsecurity.gov, or call SSA at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: keep this creditable coverage notice. If you decide to join one of the Medicare prescription drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Required Notices

Women's Health & Cancer Rights Act

The Women's Health and Cancer Rights Act (WHCRA) requires group health plans to make certain benefits available to participants who have undergone or who are going to have a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Covered under the employer-sponsored medical plan, and
- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Your plans comply with these requirements.

Health Insurance Portability & Accountability Act Non-discrimination Requirements

Health Insurance Portability & Accountability Act (HIPAA) prohibits group health plans and health insurance issuers from discriminating against individuals in eligibility and continued eligibility for benefits and in individual premium or contribution rates based on health factors.

These health factors include: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, HIPAA Special Enrollment Rights require your plan to allow you and/or your dependents to enroll in your employer's plans (except dental and vision plans elected separately from your medical plans) if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days (60 days if the lost coverage was Medicaid or Healthy Families) after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. Other midyear election changes may be permitted under your plan (refer to "Change in Status" section). To request special enrollment or obtain more information, contact your Human Resources Representative.

“HIPAA Special Enrollment Opportunities” include:

- COBRA (or state continuation coverage) exhaustion.
- Loss of other coverage ⁽¹⁾.
- Acquisition of a new spouse or dependent through marriage ⁽¹⁾, adoption ⁽¹⁾, placement for adoption ⁽¹⁾ or birth ⁽¹⁾.
- Loss of state Children’s Health Insurance Program coverage (e.g., Healthy Families)(60-day notice) ⁽¹⁾.
- Employee or dependents become eligible for state Premium Assistance Subsidy Program (60-daynotice).

“Change in Status” Permitted Midyear Election Changes

- Due to the Internal Revenue Service (IRS) regulations, in order to be eligible to take your premium contribution using pre-tax dollars, your election must be irrevocable for the entire plan year. As a result, your enrollment in the medical, dental, and vision plans or declination of coverage when you are first eligible, will remain in place until the next Open Enrollment period, unless you have an approved “change in status” as defined by the IRS.
- Examples of permitted “change in status” events include:
 - Change in legal marital status (e.g., marriage ⁽²⁾, divorce or legal separation)
 - Change in number of dependents (e.g., birth ⁽²⁾, adoption ⁽²⁾ or death)
 - Change in eligibility of a child
 - Change in your / your spouse’s / your state registered / unregistered / state registered and unregistered domestic partner’s employment status (e.g., reduction in hours affecting eligibility or change in employment)
 - A substantial change in your / your spouse’s / your state registered / unregistered / state registered and unregistered domestic partner’s benefits coverage
 - A relocation that impacts network access
 - Enrollment in state-based insurance Exchange
 - Medicare Part A or B enrollment
 - Qualified Medical Child Support Order or other judicial decree
 - A dependent’s eligibility ceases resulting in a loss of coverage ⁽³⁾
 - Loss of other coverage
 - Change in employment status where you have a reduction in hours to an average below 30 hours of service per week, but continue to be eligible for benefits, and you intend to enroll in another plan that provides Minimum Essential Coverage that is effective no later than the first day of the second month following the date of revocation of your employer sponsored coverage
 - You enroll, or intend to enroll, in a Qualified health Plan (QHP) through the State Marketplace (i.e. Exchange) and it is effective no later than the day immediately following the revocation of your employer sponsored coverage.

You must notify Human Resources within 30 days of the above change in status, with the exception of the following which requires notice within 60 days:

- Loss of eligibility or enrollment in Medicaid or state health insurance programs (e.g., Healthy Families)

HIPAA Privacy Notice

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge Regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are Required by Law to

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan Will Use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Workers' Compensation: We may release health information about you for Workers' Compensation or

similar programs. These programs provide benefits for work-related injuries or illness.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization.

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your health information;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal health information within 60 days or 5 days if conducting business in California;
- Accommodate any reasonable request you may have to communicate health information by alternative means or at alternative locations.

The plan will not use or disclose your health information without your consent or authorization, except as provided by law or described in this notice. The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

1) Indicates that this event is also a qualified "Change in Status"

2) Indicates this event is also a HIPAA Special Enrollment Right

3) Indicates that this event is also a COBRA Qualifying Event

For More Information or to Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

Important Information on How Health Care Reform Affects Your Plan

Prohibition on Excess Waiting Periods

Group health plans may not apply a waiting period that exceeds 90 days. A waiting period is defined as the period that must pass before coverage for an eligible employee or his or her dependent becomes effective under the Plan. State law may require shorter waiting periods for insured group health plans. California law requires fully-insured plans to comply with the more restrictive waiting period limitation of no more than 60-days.

Preexisting Condition Exclusion

Effective for Plan Years on or after January 1, 2014, Group health plans are prohibited from denying coverage or excluding specific benefits from coverage due to an individual's preexisting condition, regardless of the individual's age. A PCE includes any health condition or illness that is present before the coverage effective date, regardless of whether medical advice or treatment was actually received or recommended.

Employee Rights & Responsibilities under the Family Medical Leave Act

Basic Leave Entitlement

Family Medical Leave Act (FMLA) requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son or daughter, child or parent, who has a serious health condition;
or
- For a serious health condition that makes the employee unable to perform the employee's job.

Military Family Leave Entitlements

Eligible employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered servicemember during a single 12-month period. A covered servicemember is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness ⁽¹⁾; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. ⁽¹⁾

Benefits & Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

1) The FMLA definitions of "serious injury or illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".

2) Special hours of service eligibility requirements apply to airline flight crew employees.

Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least 12 months, have 1,250 hours of service in the previous 12 months (2), and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of leave

An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days' notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions; the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider; or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information: (866) 4US-WAGE ((866) 487-9243) TTY: (877) 889-5627 www.wagehour.dol.gov.

Uniformed Services Employment & Reemployment Rights Act Notice of 1994, Notice of Right to Continued Coverage under USERRA

Right to Continue Coverage

Under the Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA), you (the employee) have the right to continue the coverage that you (and your covered dependents, if any) had under the Company Medical Plan if the following conditions are met:

- You are absent from work due to service in the uniformed services (defined below);
- You were covered under the Plan at the time your absence from work began; and
- You (or an appropriate officer of the uniformed services) provided your employer with advance notice of your absence from work (you are excused from meeting this condition if compliance is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances).

How to Continue Coverage

If the conditions are met, you (or your authorized representative) may elect to continue your coverage (and the coverage of your covered dependents, if any) under the Plan by completing and returning an Election Form 60 days after date that USERRA election notice is mailed, and by paying the applicable premium for your coverage as described below.

What Happens if You Do Not Elect to Continue Coverage?

If you fail to submit a timely, completed Election Form as instructed or do not make a premium payment within the required time, you will lose your continuation rights under the Plan, unless compliance with these requirements is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

If you do not elect continuation coverage, your coverage (and the coverage of your covered dependents, if any) under the Plan ends effective the end of the month in which you stop working due to your leave for uniformed service.

Premium for Continuing Your Coverage

The premium that you must pay to continue your coverage depends on your period of service in the uniformed services. Contact Human Resources for more details.

Length of Time Coverage Can Be Continued

If elected, continuation coverage can last 24 months from the date on which employee's leave for uniformed service began. However, coverage will automatically terminate earlier if one of the following events takes place:

- A premium is not paid in full within the required time;
- You fail to return to work or apply for reemployment within the time required under USERRA (see below) following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

We will not provide advance notice to you when your continuation coverage terminates.

Reporting to Work/Applying for Reemployment


Your right to continue coverage under USERRA will end if you do not notify Human Resources of your intent to return to work within the timeframe required under USERRA following the completion of your service in the uniformed services by either reporting to work (if your uniformed service was for less than 31 days) or applying for reemployment (if your uniformed service was for more than 30 days). The time for returning to work depends on the period of uniformed service, as follows:

Period of Uniformed Service	Report to Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, then as soon as is possible.
31–180 days	Submit an application for reemployment within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, then as soon as is possible.
181 days or more	Submit an application for reemployment within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service.	Report by the beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service.	Report or submit an application for reemployment as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years from completion of service but may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods

Definition

For you to be entitled to continued coverage under USERRA, your absence from work must be due to “service in the uniformed services.”

- “Uniformed services” means the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.
- “Service in the uniformed services” or “service” means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active and inactive duty for training, National Guard duty under federal statute, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, visit [Join.Surest.com](#), Surest mobile app, [Benefits.Surest.com](#) website or call Surest Member Services at 1-866-683-6440. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms, see the Glossary. You can view the Glossary at <https://healthcare.gov/sbc-glossary/> or call 1-866-683-6440 to request a copy.

Important Questions	Answers	Why This Matters
What is the overall deductible ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	Yes	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	For network providers : \$5,500 individual / \$11,000 family For out-of-network providers : \$11,000 individual / \$22,000 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums , balance billing charges and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Will you pay less if you use a network provider ?	Yes. See Join.Surest.com or call 1-866-683-6440 for a list of network providers .	This plan uses a provider network . You will pay less if you use a provider in the plan's network . You will pay the most if you use an out-of-network provider , and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No	You can see the specialist you choose without a referral .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$35 - \$135 copayment /visit	\$480 copayment /visit	<p>Certain procedures performed in the office may have a higher office visit copayment.</p> <p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Virtual visits - \$35 copayment per visit by a Designated Virtual Network Provider.</p> <p>*Cost share applies to any other Telehealth service based on provider type. If you receive services in addition to office visit, additional copayments may apply.</p>
	Specialist visit	\$35 - \$135 copayment /visit	\$480 copayment /visit	
	Preventive care/ screening/ immunization	No charge	\$330 copayment /visit	
If you have a test	Diagnostic test (e.g., x-ray, blood work)	<p>Routine diagnostic test: No charge</p> <p>Non-routine diagnostic test: Up to \$1,000 copayment/visit</p>	<p>Routine diagnostic test: No charge</p> <p>Non-routine diagnostic test: Up to \$3,000 copayment/visit</p>	<p>You may have to pay for services that are not preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.</p> <p>None</p>
	Imaging (CT/PET scans, MRIs)	\$210 - \$740 copayment /visit	\$2,400 copayment /visit	<p>Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.</p> <p>Prior authorization is required for certain imaging tests or there may be no coverage.</p>

*For more information about limitations and exceptions, see the [plan](#) or policy document at [Join.Surest.com](#). After you enroll visit the Surest mobile app or [Benefits.Surest.com](#) website.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
<p>If you need drugs to treat your illness or condition</p> <p>More information about prescription drug coverage is available at Join.Surest.com.</p>	Tier 1 drugs	<p>30-Day Supply \$5 copayment at Preferred Pharmacies; \$5 copayment at other network pharmacies</p> <p>90-Day Supply \$15 copayment at Preferred Pharmacies or Kroger Mail Order; \$15 copayment at other network pharmacies</p>	Not covered	<p>Certain Tier 1 drugs are available with \$0 copayments, including prescribed generic contraceptives and tobacco cessation medications.</p> <p>To learn more about drug tiers and about copayments for specific drugs, visit Join.Surest.com, the Surest mobile app or Benefits.Surest.com website.</p> <p>Prior authorization is required for certain drugs or there may be no coverage.</p>
	Tier 2 drugs	<p>30-Day Supply \$30 copayment at Preferred Pharmacies and other network pharmacies</p> <p>90-Day Supply \$75 copayment at Preferred Pharmacies, other network pharmacies or Kroger Mail Order</p>	Not covered	
	Tier 3 drugs	<p>30-Day Supply \$145 copayment at Preferred Pharmacies and other network pharmacies</p> <p>90-Day Supply \$362 copayment at Preferred Pharmacies, other network pharmacies or Kroger Mail Order</p>	Not covered	
	Specialty drugs	<p>30-Day Supply Tier 1: \$145 copayment Tier 2: \$145 copayment Tier 3: \$145 copayment</p>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$65 - \$3,750 copayment /visit	Up to \$10,000 copayment /visit	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for certain outpatient surgery or there may be no coverage.
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	\$700 copayment /visit	\$700 copayment /visit	Copayment is waived if admitted within 24 hours. Out-of-network emergency room care visit copayment applies to the in-network out-of-pocket limit . Prior authorization is required for non- emergency medical transportation or there may be no coverage. Out-of-network emergency medical transportation copayment applies to the in-network out-of-pocket limit .
	Emergency medical transportation	\$650 copayment /transport	\$650 copayment /transport	
	Urgent care	\$80 copayment /visit	\$240 copayment /visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$600 - \$3,750 copayment /stay	Up to \$10,000 copayment /stay	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for non-emergency facility admissions and inpatient surgery or there may be no coverage.
	Physician/surgeon fees	No charge	No charge	

*For more information about limitations and exceptions, see the [plan](#) or policy document at [Join.Surest.com](#). After you enroll visit the Surest mobile app or [Benefits.Surest.com](#) website.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Home/Office: \$35 copayment /visit Outpatient Facility: \$150 copayment /visit	Home/Office: \$330 copayment /visit Outpatient Facility: \$450 copayment /visit	Certain procedures/services in the outpatient setting may have a lower copayment . Prior authorization is required for certain outpatient services or there may be no coverage. Certain procedures/services in the inpatient setting may have a lower copayment . Prior authorization is required for certain inpatient services or there may be no coverage.
	Inpatient services	\$2,550 copayment /stay	\$8,000 copayment /stay	Cost sharing does not apply to preventive services with network providers . Depending on the type of service, a copayment may apply.
If you are pregnant	Office visits	No charge	\$330 copayment /visit	One copayment for all covered services related to childbirth/delivery, including the newborn, unless discharged after mother.
	Childbirth/delivery professional services	No charge	No charge	Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care. Prior authorization is required for inpatient stays beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery or there may be no coverage.
	Childbirth/delivery facility services	\$1,350 - \$3,050 copayment /stay	\$10,000 copayment /stay	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	\$35 copayment/visit	\$140 copayment/visit	No visit limit. Prior authorization is required for certain home health care services or there may be no coverage.
	Rehabilitation services	\$15 - \$40 copayment/visit	Up to \$100 copayment/visit	No visit limit for occupational therapy, physical therapy, and speech therapy. Copayments are listed as a range. Providers are assigned copayments within the range based on treatment outcomes and cost information that identifies network providers that provide cost-efficient care.
	Habilitation services	\$15 - \$40 copayment/visit	Up to \$100 copayment/visit	No visit limit. Prior authorization is required or there may be no coverage.
	Skilled nursing care	\$1,900 copayment/ stay	\$9,000 copayment/ stay	For durable medical equipment (DME) tiers and limitations, visit Join.Surest.com , the Surest mobile app or Benefits.Surest.com website. Prior authorization is required for certain DME or there may be no coverage.
If your child needs dental or eye care	Durable medical equipment	\$0 - \$1,000 copayment/visit equipment based on DME tier	Up to \$2,000 copayment/visit equipment based on DME tier	None
	Hospice services	Home: \$35 copayment/visit Inpatient: \$2,550 copayment/ stay	Home: \$260 copayment/visit Inpatient: \$8,000 copayment/ stay	One exam per person per plan year
	Children's eye exam	No charge	\$480 copayment/visit	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

*For more information about limitations and exceptions, see the [plan](#) or policy document at [Join.Surest.com](#). After you enroll visit the Surest mobile app or [Benefits.Surest.com](#) website.

Excluded Services & Other Covered Services:

Services Your [Plan](#) Generally Does NOT Cover (Check your [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long term care
- Non-emergency care when traveling outside the U.S.
- Private duty nursing
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture (12 visit limit per person per [plan](#) year)
- Chiropractic care (12 visit limit per person per [plan](#) year)
- Bariatric surgery
- Routine eye care (Adult) (limited to one exam per person per [plan](#) year.)
- Infertility treatment (limitations apply)
- Routine foot care (for certain conditions)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform. You may also contact Surest Member Services at 1-866-683-6440. Other coverage options may be available to you too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Surest Member Services at 1-866-683-6440, or the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or dol.gov/ebsa/healthreform.

Does this [plan](#) provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this [plan](#) meet the Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-683-6440.

To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#), and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$0
- Hospital (facility) [copayment](#) \$3,050
- Other [copayments](#) \$500

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost	\$12,700
In this example, Peg would pay:	
Cost sharing	
Deductibles	\$0
Copayments	\$3,550
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Peg would pay is	\$3,570

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$0
- Other [copayments](#) \$1,000

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)
[Diagnostic tests](#) (*blood work*)
[Prescription drugs](#)
[Durable medical equipment](#) (*glucose meter*)

Total Example Cost	\$5,600
In this example, Joe would pay:	
Cost sharing	
Deductibles	\$0
Copayments	\$1,070
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Joe would pay is	\$1,070

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$0
- [Specialist copayment](#) \$70
- Hospital (facility) [copayment](#) \$700
- Other [copayments](#) \$800

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)
[Diagnostic tests](#) (*x-ray*)
[Durable medical equipment](#) (*crutches*)
[Rehabilitation services](#) (*physical therapy*)

Total Example Cost	\$2,800
In this example, Mia would pay:	
Cost sharing	
Deductibles	\$0
Copayments	\$1,570
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,570

The [plan](#) would be responsible for the other costs of these **EXAMPLE** covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.askallegiance.com/ARUP or call 1-855-999-2279. For general definitions of common terms, such as [allowed amount](http://www.dol.gov/ebsa/healthreform), [balance billing](http://www.dol.gov/ebsa/healthreform), [coinsurance](http://www.dol.gov/ebsa/healthreform), [copayment](http://www.dol.gov/ebsa/healthreform), [deductible](http://www.dol.gov/ebsa/healthreform), [provider](http://www.dol.gov/ebsa/healthreform), or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cms.gov or call 1-855-999-2279 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$750 individual/\$1,500 family network and non-network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible (embedded) until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Preventive care is not subject to <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at http://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$4,000 individual/\$8,000 family network and non-network, medical and pharmacy combined.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> (embedded) until the overall family <u>out-of-pocket limits</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.askallegiance.com/ARUP or call 1-855-999-2279 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what you <u>plan pays</u> (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No	You can see the <u>specialist</u> you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	35% coinsurance	None
	Specialist visit	15% coinsurance	35% coinsurance	None
	Preventive care/screening/immunization	No charge deductible waived	35% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	None
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.askallegiance.com/ARUP or 1-855-999-2279, or www.navitus.com or 1-855-673-6504.	Tier 1 drugs	PBM Retail: \$5 copayment 1-30 day supply \$10 copayment 31-60 day supply \$15 copayment 61-90 day supply Mail order: \$5 copayment 1-30 day supply \$10 copayment 31-60 day supply \$12.50 copayment 61-90 day supply		Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program.
	Tier 2 drugs	PBM Retail: \$30 copayment 1-30 day supply \$60 copayment 31-60 day supply \$90 copayment 61-90 day supply Mail order: \$30 copayment 1-30 day supply \$60 copayment 31-60 day supply \$75 copayment 61-90 day supply		If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Copayments may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA).
	Tier 3 drugs	PBM Retail: 35% copayment (\$145 maximum) 1-30 day supply 35% copayment (\$290 maximum) 31-60 day supply 35% copayment (\$435 maximum) 61-90 day supply Mail order: 35% copayment (\$145 maximum) 1-30 day supply 35% copayment (\$290 maximum) 31-60 day supply 35% copayment (\$375 maximum) 61-90 day supply		Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill.
	Specialty drugs	35% copayment (\$145 maximum) 1-30 day supply	35% copayment (\$145 maximum) 1-30 day supply	Specialty prescriptions must be obtained from a specialty pharmacy. Enrollment in Specialty Access Program for certain specialty drugs is mandatory and requires prior authorization through Navitus.
	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	Pre-treatment review recommended for certain surgeries.
If you have outpatient surgery	Physician/surgeon fees	15% coinsurance	35% coinsurance	

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ARUP or call 1-855-999-2279.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you need immediate medical attention	Emergency room care	\$250 copayment, then 15% coinsurance	15% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	15% coinsurance		None
	Urgent care	15% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office visits	15% coinsurance, deductible waived	35% coinsurance	None
	Outpatient services	15% coinsurance	35% coinsurance	None
	Inpatient services	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions.
	Office visits	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive services.
If you are pregnant	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Home health care	15% coinsurance	35% coinsurance	Pre-treatment review recommended.
	Rehabilitation services	15% coinsurance	35% coinsurance	Pre-treatment review recommended.
	Habilitation services	15% coinsurance	35% coinsurance	None
	Skilled nursing care	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions.
	Durable medical equipment	15% coinsurance	35% coinsurance	Pre-treatment review recommended for charges exceeding \$5,000. Option to purchase CPAP machine following 3 months rental. Durable medical equipment otherwise limited to rental up to purchase price.
	Hospice services	15% coinsurance	35% coinsurance	Coverage includes 14 days respite care per covered person per hospice benefit period (hospice incident). Bereavement counseling is not covered under the medical plan. Bereavement counseling services are covered under the employee assistance program. Pre-certification recommended for all inpatient admissions.
If your child needs dental or eye care	Children's eye exam	No charge deductible waived, age 18 or older (eye exam not otherwise covered under Preventive care)		Coverage limited to 1 exam, including refraction and retinal screening per benefit period. Non-routine eye exam subject to deductible and coinsurance. This benefit can be waived, though waiver does not change the required contribution.
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ARUP or call 1-855-999-2279.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your plan. For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or www.cciio.cms.gov, www.askallegiance.com/ARUP or call 1-855-999-2279. Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at www.dol.gov/ebsa/healthreform, or www.cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes

If your plan doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a plan through the Marketplace.

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

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ARUP or call 1-855-999-2279.

About these Coverage Examples:



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Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- The [plan's overall deductible](#) \$750
- [Specialist coinsurance](#) 15%
- [Hospital \(facility\) coinsurance](#) 15%
- [Other coinsurance](#) 15%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$10
Coinsurance	\$1,800
Limits or exclusions \$60	
The total Peg would pay is	\$2,620

What isn't covered

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- The [plan's overall deductible](#) \$750
- [Specialist coinsurance](#) 15%
- [Hospital \(facility\) coinsurance](#) 15%
- [Other coinsurance](#) 15%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$500
Coinsurance	\$200
Limits or exclusions \$20	
The total Joe would pay is	\$1,470

What isn't covered

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- The [plan's overall deductible](#) \$750
- [Specialist coinsurance](#) 15%
- [Hospital \(facility\) coinsurance](#) 15%
- [Other coinsurance](#) 15%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$750
Copayments	\$300
Coinsurance	\$300
Limits or exclusions \$0	
The total Mia would pay is	\$1,350

What isn't covered

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.



The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.askallegiance.com/ARUP or call 1-855-999-2279. For general definitions of common terms, such as [allowed amount](http://www.dol.gov/ebsa/healthreform), [balance billing](http://www.dol.gov/ebsa/healthreform), [coinsurance](http://www.dol.gov/ebsa/healthreform), [copayment](http://www.dol.gov/ebsa/healthreform), [deductible](http://www.dol.gov/ebsa/healthreform), [provider](http://www.dol.gov/ebsa/healthreform), or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform and www.cms.gov or call 1-855-999-2279 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	\$1,500 individual/\$3,000 family network and non-network	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual deductible until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
Are there services covered before you meet your <u>deductible</u>?	Yes. Preventive care is not subject to <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't met the <u>deductible</u> amount, but a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain preventive services without <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at http://www.healthcare.gov/coverage/preventive-care-benefits .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u>?	\$4,000 individual/\$8,000 family network and non-network, medical and pharmacy combined.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limits</u> has been met.
What is not included in the <u>out-of-pocket limit</u>?	<u>Premiums</u> , <u>balance billing</u> charges (unless <u>balanced billing</u> is prohibited), and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u>?	Yes. See www.askallegiance.com/ARUP or call 1-855-999-2279 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's charge</u> and what you <u>plan pays</u> (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No	You can see the <u>specialist</u> you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	15% coinsurance	35% coinsurance	None	
	Specialist visit	15% coinsurance	35% coinsurance	None	
	Preventive care/screening/immunization	No charge deductible waived	35% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.	
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	35% coinsurance	None	
	Imaging (CT/PET scans, MRIs)	15% coinsurance	35% coinsurance	None	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.askallegiance.com/ARUP or 1-855-999-2279, or www.navitus.com or 1-855-673-6504.	Tier 1 drugs	PBM Retail: \$5 copayment 1-30 day supply \$10 copayment 31-60 day supply \$15 copayment 61-90 day supply Mail order: \$5 copayment 1-30 day supply \$10 copayment 31-60 day supply \$12.50 copayment 61-90 day supply	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Copayments may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA).	Charges payable through the Plan's Pharmacy Benefit Manager (PBM) program. If Physician does not prescribe "Dispense as Written" (DAW), and there is a generic alternative, and covered person chooses a brand name instead, covered person must pay the difference in cost between generic and brand plus applicable brand copayment amount. Copayments may not apply to preventive care drugs as outlined in the Affordable Care Act (PPACA).	
	Tier 2 drugs	PBM Retail: \$30 copayment 1-30 day supply \$60 copayment 31-60 day supply \$90 copayment 61-90 day supply Mail order: \$30 copayment 1-30 day supply \$60 copayment 31-60 day supply \$75 copayment 61-90 day supply	PBM Retail: 35% copayment (\$145 maximum) 1-30 day supply 35% copayment (\$290 maximum) 31-60 day supply 35% copayment (\$435 maximum) 61-90 day supply Mail order: 35% copayment (\$145 maximum) 1-30 day supply 35% copayment (\$290 maximum) 31-60 day supply 35% copayment (\$375 maximum) 61-90 day supply	Certain prescriptions require prior authorization before the drug can be dispensed or before obtaining a second fill.	Specialty prescriptions must be obtained from a specialty pharmacy. Enrollment in Specialty Access Program for certain specialty drugs is mandatory and requires prior authorization through Navitus.
	Tier 3 drugs	PBM Retail: 35% copayment (\$145 maximum) 1-30 day supply 35% copayment (\$290 maximum) 31-60 day supply 35% copayment (\$435 maximum) 61-90 day supply Mail order: 35% copayment (\$145 maximum) 1-30 day supply 35% copayment (\$290 maximum) 31-60 day supply 35% copayment (\$375 maximum) 61-90 day supply	35% copayment (\$145 maximum) 1-30 day supply	Specialty prescriptions must be obtained from a specialty pharmacy. Enrollment in Specialty Access Program for certain specialty drugs is mandatory and requires prior authorization through Navitus.	Specialty prescriptions must be obtained from a specialty pharmacy. Enrollment in Specialty Access Program for certain specialty drugs is mandatory and requires prior authorization through Navitus.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	35% coinsurance	Pre-treatment review recommended for certain surgeries.	
	Physician/surgeon fees	15% coinsurance	35% coinsurance		

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ARUP or call 1-855-999-2279.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
If you need immediate medical attention	Emergency room care	\$250 copayment, then 15% coinsurance	15% coinsurance	Copayment waived if admitted.
	Emergency medical transportation	15% coinsurance	15% coinsurance	None
	Urgent care	15% coinsurance	35% coinsurance	None
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions. Pre-treatment review recommended for certain surgeries.
	Physician/surgeon fees	15% coinsurance	35% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Office visit	15% coinsurance, deductible waived	35% coinsurance	None
	Outpatient services	15% coinsurance	35% coinsurance	None
	Inpatient services	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions.
If you are pregnant	Office visits	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions exceeding 48 hours vaginal delivery or 96 hours C-Section. Cost sharing does not apply for preventive services. Depending on the type of services, deductible and coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	15% coinsurance	35% coinsurance	
	Childbirth/delivery facility services	15% coinsurance	35% coinsurance	
	Home health care	15% coinsurance	35% coinsurance	
	Rehabilitation services	15% coinsurance	35% coinsurance	
If you need help recovering or have other special health needs	Skilled nursing care	15% coinsurance	35% coinsurance	Pre-certification recommended for all inpatient admissions.
	Durable medical equipment	15% coinsurance	35% coinsurance	Pre-treatment review recommended for charges exceeding \$5,000. Option to purchase CPAP machine following 3 months rental. Durable medical equipment otherwise limited to rental up to purchase price.
	Hospice services	15% coinsurance	35% coinsurance	Coverage includes 14 days respite care per covered person per hospice benefit period (hospice incident). Bereavement counseling is not covered under the medical plan. Bereavement counseling services are covered under the employee assistance program. Pre-certification recommended for all inpatient admissions.
If your child needs dental or eye care	Children's eye exam	No charge deductible waived, age 18 or older (eye exam not otherwise covered under Preventive care)		Coverage limited to 1 exam, including refraction and retinal screening per benefit period. Non-routine eye exam subject to deductible and coinsurance. This benefit can be waived, though waiver does not change the required contribution.
	Children's glasses	Not covered	Not covered	None

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ARUP or call 1-855-999-2279.



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	Limitations & Exceptions
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Non-emergency care when traveling outside of the U.S.
- Private-duty nursing
- Routine eye care (Adult)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.ccio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, Department of Health and Human Services, Center for Consumer Information and Insurance Oversight at: 1-877-267-2323 x61565 or www.ccio.cms.gov, www.askallegiance.com/ARUP or call 1-855-999-2279. Additionally, a consumer assistance program can help you file your appeal. Consumer assistance programs available at www.dol.gov/ebsa/healthreform, or www.ccio.cms.gov/programs/consumer/cappgrants/index.html.

Does this plan provide Minimum Essential Coverage? **Yes**

[Minimum Essential Coverage](#) generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

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

For more information about limitations and exceptions, see the plan or policy document at www.askallegiance.com/ARUP or call 1-855-999-2279.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** \$1,500
- [Specialist coinsurance](#) 15%
- [Hospital \(facility\) coinsurance](#) 15%
- [Other coinsurance](#) 15%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost \$12,800

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$10
Coinsurance	\$1,700
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$3,270

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

- **The plan's overall deductible** \$1,500
- [Specialist coinsurance](#) 15%
- [Hospital \(facility\) coinsurance](#) 15%
- [Other coinsurance](#) 15%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$500
Coinsurance	\$60
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$2,080

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

- **The plan's overall deductible** \$1,500
- [Specialist coinsurance](#) 15%
- [Hospital \(facility\) coinsurance](#) 15%
- [Other coinsurance](#) 15%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,500
Copayments	\$300
Coinsurance	\$100
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,900

Note: The cost sharing amounts in the Coverage Examples are based on the CMS Cost Sharing Calculator (CECSC) www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/index.html used to estimate out-of-pocket expenses. The coverage examples are estimated costs only, and may not accurately reflect actual costs. The actual care you receive will be different from these examples, and the cost of that care will also be different.

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Glossary of Health Coverage and Medical Terms

- This glossary defines many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your [plan](#) or [health insurance](#) policy. Some of these terms also might not have exactly the same meaning when used in your policy or [plan](#), and in any case, the policy or [plan](#) governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or [plan](#) document.)
- [Underlined](#) text indicates a term defined in this Glossary.
- See page 6 for an example showing how [deductibles](#), [coinsurance](#) and [out-of-pocket limits](#) work together in a real life situation.

Allowed Amount

This is the maximum payment the [plan](#) will pay for a covered health care service. May also be called “eligible expense,” “payment allowance,” or “negotiated rate.”

Appeal

A request that your health insurer or [plan](#) review a decision that denies a benefit or payment (either in whole or in part).

Balance Billing

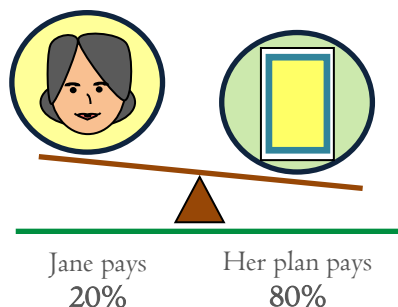
When a [provider](#) bills you for the balance remaining on the bill that your [plan](#) doesn't cover. This amount is the difference between the actual billed amount and the [allowed amount](#). For example, if the provider's charge is \$200 and the allowed amount is \$110, the provider may bill you for the remaining \$90. This happens most often when you see an [out-of-network provider](#) ([non-preferred provider](#)). A [network provider](#) ([preferred provider](#)) may not balance bill you for covered services.

Claim

A request for a benefit (including reimbursement of a health care expense) made by you or your health care [provider](#) to your health insurer or [plan](#) for items or services you think are covered.

Coinsurance

Your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the [allowed amount](#) for the service. You generally pay coinsurance *plus* any [deductibles](#) you owe. (For example, if the [health insurance](#) or [plan's](#) allowed amount for an office visit is \$100 and you've met your [deductible](#), your coinsurance payment of 20% would be \$20. The [health insurance](#) or [plan](#) pays the rest of the allowed amount.)



(See page 6 for a detailed example.)

Complications of Pregnancy

Conditions due to pregnancy, labor, and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section generally aren't complications of pregnancy.

Copayment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service (sometimes called “copay”). The amount can vary by the type of covered health care service.

Cost Sharing

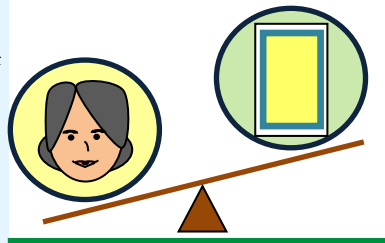
Your share of costs for services that a [plan](#) covers that you must pay out of your own pocket (sometimes called “out-of-pocket costs”). Some examples of cost sharing are [copayments](#), [deductibles](#), and [coinsurance](#). Family cost sharing is the share of cost for [deductibles](#) and [out-of-pocket](#) costs you and your spouse and/or child(ren) must pay out of your own pocket. Other costs, including your [premiums](#), penalties you may have to pay, or the cost of care a [plan](#) doesn't cover usually aren't considered cost sharing.

Cost-sharing Reductions

Discounts that reduce the amount you pay for certain services covered by an individual [plan](#) you buy through the [Marketplace](#). You may get a discount if your income is below a certain level, and you choose a Silver level health plan or if you're a member of a federally-recognized tribe, which includes being a shareholder in an Alaska Native Claims Settlement Act corporation.

Deductible

An amount you could owe during a coverage period (usually one year) for covered health care services before your [plan](#) begins to pay. An overall deductible applies to all or almost all covered items and services. A [plan](#) with an overall deductible may also have separate deductibles that apply to specific services or groups of services. A [plan](#) may also have only separate deductibles. (For example, if your deductible is \$1000, your plan won't pay anything until you've met your \$1000 deductible for covered health care services subject to the deductible.)



Jane pays 100% Her plan pays 0%
(See page 6 for a detailed example.)

Diagnostic Test

Tests to figure out what your health problem is. For example, an x-ray can be a diagnostic test to see if you have a broken bone.

Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care [provider](#) for everyday or extended use. DME may include: oxygen equipment, wheelchairs, and crutches.

Emergency Medical Condition

An illness, injury, symptom (including severe pain), or condition severe enough to risk serious danger to your health if you didn't get medical attention right away. If you didn't get immediate medical attention you could reasonably expect one of the following: 1) Your health would be put in serious danger; or 2) You would have serious problems with your bodily functions; or 3) You would have serious damage to any part or organ of your body.

Emergency Medical Transportation

Ambulance services for an [emergency medical condition](#). Types of emergency medical transportation may include transportation by air, land, or sea. Your [plan](#) may not cover all types of emergency medical transportation, or may pay less for certain types.

Emergency Room Care / Emergency Services

Services to check for an [emergency medical condition](#) and treat you to keep an [emergency medical condition](#) from getting worse. These services may be provided in a licensed hospital's emergency room or other place that provides care for [emergency medical conditions](#).

Excluded Services

Health care services that your [plan](#) doesn't pay for or cover.

Formulary

A list of drugs your [plan](#) covers. A formulary may include how much your share of the cost is for each drug. Your [plan](#) may put drugs in different [cost-sharing](#) levels or tiers. For example, a formulary may include generic drug and brand name drug tiers and different [cost-sharing](#) amounts will apply to each tier.

Grievance

A complaint that you communicate to your health insurer or [plan](#).

Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance

A contract that requires a health insurer to pay some or all of your health care costs in exchange for a [premium](#). A health insurance contract may also be called a "policy" or "[plan](#)."

Home Health Care

Health care services and supplies you get in your home under your doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed health care [providers](#). Home health care usually doesn't include help with non-medical tasks, such as cooking, cleaning, or driving.

Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. Some [plans](#) may consider an overnight stay for observation as outpatient care instead of inpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

In-network Coinsurance

Your share (for example, 20%) of the [allowed amount](#) for covered health care services. Your share is usually lower for in-network covered services.

In-network Copayment

A fixed amount (for example, \$15) you pay for covered health care services to [providers](#) who contract with your [health insurance](#) or [plan](#). In-network copayments usually are less than [out-of-network copayments](#).

Marketplace

A marketplace for [health insurance](#) where individuals, families and small businesses can learn about their [plan](#) options; compare plans based on costs, benefits and other important features; apply for and receive financial help with [premiums](#) and [cost sharing](#) based on income; and choose a [plan](#) and enroll in coverage. Also known as an “Exchange.” The Marketplace is run by the state in some states and by the federal government in others. In some states, the Marketplace also helps eligible consumers enroll in other programs, including Medicaid and the Children’s Health Insurance Program (CHIP). Available online, by phone, and in-person.

Maximum Out-of-pocket Limit

Yearly amount the federal government sets as the most each individual or family can be required to pay in [cost sharing](#) during the [plan](#) year for covered, in-network services. Applies to most types of health [plans](#) and insurance. This amount may be higher than the [out-of-pocket limits](#) stated for your [plan](#).

Medically Necessary

Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms, including habilitation, and that meet accepted standards of medicine.

Minimum Essential Coverage

Minimum essential coverage generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of minimum essential coverage, you may not be eligible for the [premium tax credit](#).

Minimum Value Standard

A basic standard to measure the percent of permitted costs the [plan](#) covers. If you’re offered an employer [plan](#) that pays for at least 60% of the total allowed costs of benefits, the [plan](#) offers minimum value and you may not qualify for [premium tax credits](#) and [cost-sharing reductions](#) to buy a [plan](#) from the [Marketplace](#).

Network

The facilities, [providers](#) and suppliers your health insurer or [plan](#) has contracted with to provide health care services.

Network Provider (Preferred Provider)

A [provider](#) who has a contract with your [health insurer](#) or [plan](#) who has agreed to provide services to members of a [plan](#). You will pay less if you see a [provider](#) in the [network](#). Also called “preferred provider” or “participating provider.”

Orthotics and Prosthetics

Leg, arm, back and neck braces, artificial legs, arms, and eyes, and external breast prostheses after a mastectomy. These services include: adjustment, repairs, and replacements required because of breakage, wear, loss, or a change in the patient’s physical condition.

Out-of-network Coinsurance

Your share (for example, 40%) of the [allowed amount](#) for covered health care services to [providers](#) who don’t contract with your [health insurance](#) or [plan](#). Out-of-network coinsurance usually costs you more than [in-network coinsurance](#).

Out-of-network Copayment

A fixed amount (for example, \$30) you pay for covered health care services from [providers](#) who do *not* contract with your [health insurance](#) or [plan](#). Out-of-network copayments usually are more than [in-network copayments](#).

Out-of-network Provider (Non-Preferred Provider)

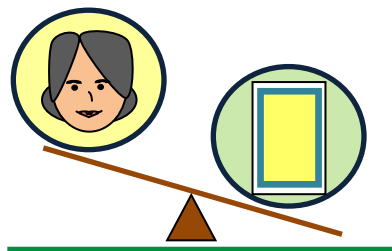
A [provider](#) who doesn’t have a contract with your [plan](#) to provide services. If your [plan](#) covers out-of-network services, you’ll usually pay more to see an out-of-network provider than a [preferred provider](#). Your policy will explain what those costs may be. May also be called “non-preferred” or “non-participating” instead of “out-of-network provider.”

Out-of-pocket Limit

The most you *could* pay during a coverage period (usually one year) for your share of the costs of covered services.

After you meet this limit the [plan](#) will usually pay 100% of the [allowed amount](#). This limit helps you plan for

health care costs. This limit never includes your [premium](#), [balance-billed](#) charges or health care your [plan](#) doesn't cover. Some [plans](#) don't count all of your [copayments](#), [deductibles](#), [coinsurance](#) payments, out-of-network payments, or other expenses toward this limit.



Jane pays
0%

Her plan pays
100%

(See page 6 for a detailed example.)

Physician Services

Health care services a licensed medical physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), provides or coordinates.

Plan

Health coverage issued to you directly (individual plan) or through an employer, union or other group sponsor (employer group plan) that provides coverage for certain health care costs. Also called “health insurance plan,” “policy,” “health insurance policy,” or “[health insurance](#).”

Preauthorization

A decision by your health insurer or [plan](#) that a health care service, treatment plan, [prescription drug](#) or [durable medical equipment \(DME\)](#) is [medically necessary](#). Sometimes called “prior authorization,” “prior approval,” or “precertification.” Your [health insurance](#) or [plan](#) may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your [health insurance](#) or [plan](#) will cover the cost.

Premium

The amount that must be paid for your [health insurance](#) or [plan](#). You and/or your employer usually pay it monthly, quarterly, or yearly.

Premium Tax Credits

Financial help that lowers your taxes to help you and your family pay for private [health insurance](#). You can get this help if you get [health insurance](#) through the [Marketplace](#) and your income is below a certain level. Advance payments of the tax credit can be used right away to lower your monthly [premium](#) costs.

Prescription Drug Coverage

Coverage under a [plan](#) that helps pay for [prescription drugs](#). If the plan's [formulary](#) uses “tiers” (levels), prescription drugs are grouped together by type or cost. The amount you'll pay in [cost sharing](#) will be different for each “tier” of covered [prescription drugs](#).

Prescription Drugs

Drugs and medications that by law require a prescription.

Preventive Care (Preventive Service)

Routine health care, including [screenings](#), check-ups, and patient counseling, to prevent or discover illness, disease, or other health problems.

Primary Care Physician

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), who provides or coordinates a range of health care services for you.

Primary Care Provider

A physician, including an M.D. (Medical Doctor) or D.O. (Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law and the terms of the [plan](#), who provides, coordinates, or helps you access a range of health care services.

Provider

An individual or facility that provides health care services. Some examples of a provider include a doctor, nurse, chiropractor, physician assistant, hospital, surgical center, skilled nursing facility, and rehabilitation center. The [plan](#) may require the provider to be licensed, certified, or accredited as required by state law.

Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries, or medical conditions.

Referral

A written order from your [primary care provider](#) for you to see a [specialist](#) or get certain health care services. In many health maintenance organizations (HMOs), you need to get a referral before you can get health care services from anyone except your [primary care provider](#). If you don't get a referral first, the [plan](#) may not pay for the services.

Rehabilitation Services

Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Screening

A type of [preventive care](#) that includes tests or exams to detect the presence of something, usually performed when you have no symptoms, signs, or prevailing medical history of a disease or condition.

Skilled Nursing Care

Services performed or supervised by licensed nurses in your home or in a nursing home. Skilled nursing care is **not** the same as "skilled care services," which are services performed by therapists or technicians (rather than licensed nurses) in your home or in a nursing home.

Specialist

A [provider](#) focusing on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Specialty Drug

A type of [prescription drug](#) that, in general, requires special handling or ongoing monitoring and assessment by a health care professional, or is relatively difficult to dispense. Generally, specialty drugs are the most expensive drugs on a [formulary](#).

UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what [providers](#) in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the [allowed amount](#).

Urgent Care

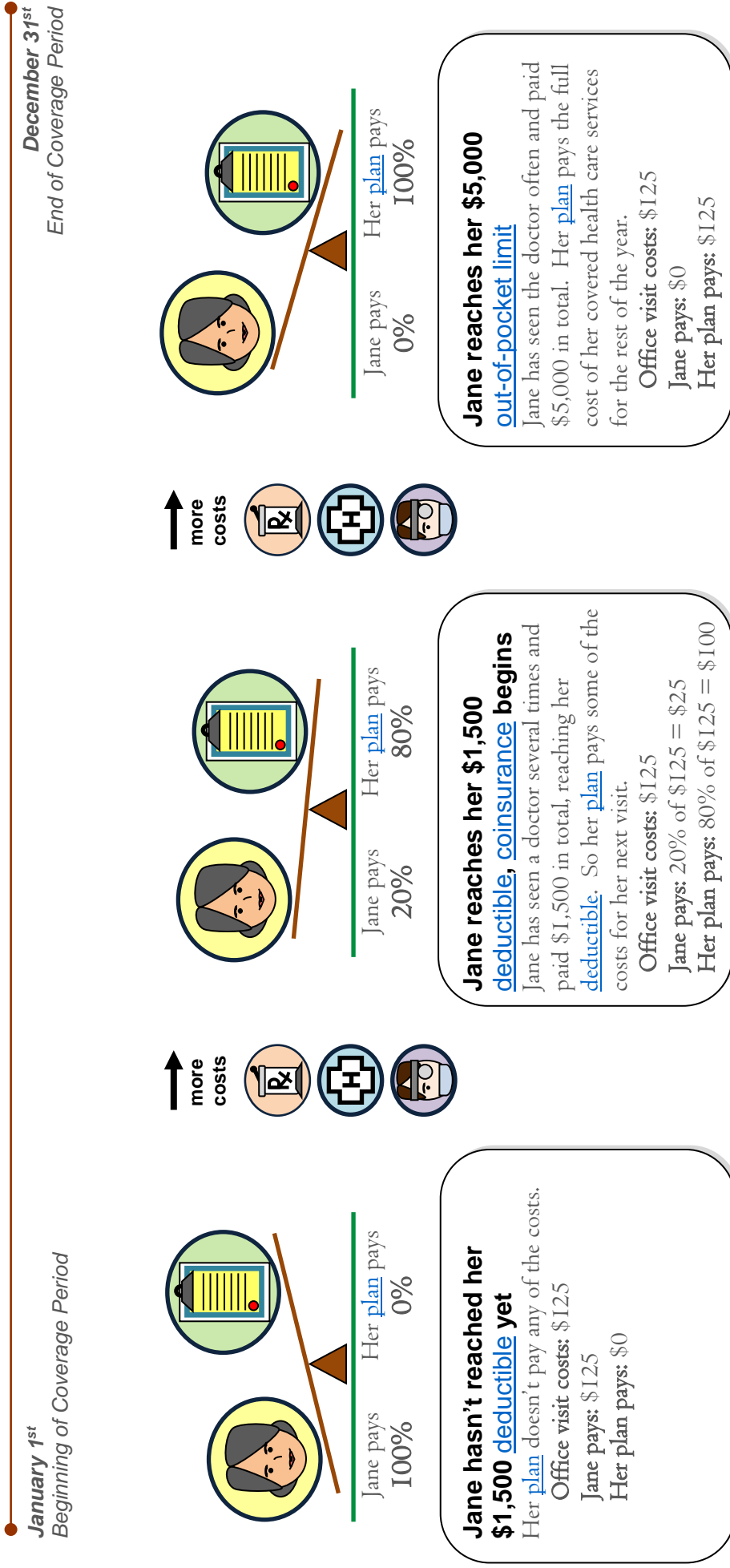
Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require [emergency room care](#).

How You and Your Insurer Share Costs - Example

Jane's Plan Deductible: \$1,500

Coinsurance: 20%

Out-of-Pocket Limit: \$5,000



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Language Access Services: The information below is a requirement of Section 1557 of the Affordable Care Act effective August 18, 2016. It is required to assist those who may need assistance with the English language or translation assistance to a different language in which they are more fluent.

فتاهبكم: (1-855-999-1062 . مقر) 1063-999-855 مقبر صلتا . نجاملبا لك فراوتتديتوغلا ةعدساملا تامدخ نإة ،تغللا ركذا ثدحتتنتك الإ :تطوولم لاء ملصا

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-999-1062 (TTY: 1-855-999-1063)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-999-1062 (TTY: 1-855-999-1063).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-999-1062 (ATS: 1-855-999-1063).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-999-1062 (TTY: 1-855-999-1063).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-999-1062 (TTY: 1-855-999-1063).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-999-1062 (TTY: 1-855-999-1063) まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-999-1062 (TTY: 1-855-999-1063) 번으로 전화해 주십시오.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-999-1062 (TTY: 1-855-999-1063).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-855-999-1062 (TTY: 1-855-999-1063).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-999-1062 (телетайп: 1-855-999-1063).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-999-1062 (TTY: 1-855-999-1063).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-999-1062 (TTY: 1-855-999-1063).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-999-1062 (TTY: 1-855-999-1063).